FAX REFERRAL FORM

FAX FORM TO: (937) 439-3786

Today's Date: ______________________

Please Schedule an Appointment:

❒ **Urgent (Call 937-439-1154)** ❒ **First Available PMD Sleep Physician***

❒ **Ali*** ❒ **Desai** ❒ **Hussein** ❒ **Iberico*** ❒ **Razi** ❒ **Shah*** ❒ **First Available**

❒ **PFT only** ❒ **Pre-Op Clearance**

Please Print Legibly

Referred By: ______________________________________ Phone: ___________________________________

Your Fax: _______________________________ Office Contact Name: ______________________________

Reason for Referral: ____

Patients Name: ____ DOB: __________________________

Patients Address: ____

City: ____ Zip: ________________________

Home Phone: _______________________ Work: ________________________ Cell: _____________________

Patient's Insurance: ____ ❒ Referral Required

Last 4 digits of Patient's Social Security Number XXX-XX __________

YOU MUST FAX all pertinent medical records, i.e. labs, x-ray reports, medication list, demographics and insurance cards WITH REFERRAL to 937-439-3786.

WE CANNOT SCHEDULE YOUR PATIENT WITHOUT THIS INFORMATION.

PLEASE ORDER A CHEST X-RAY IF ONE HAS NOT BEEN DONE IN PAST 12 MONTHS.

Scheduled Appointment:

❒ **Kettering**

Date: ___________________ **Time:** __________________ **Doctor:** ____________________ ❒ **Sycamore**

(Revised 6/2016)