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** ❒ **Gleason** ❒ **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:

Date: _____ Time: _____ Doctor: _____

❒**Kettering**

❒**Sycamore**

(Revised 1/18)