EASY FAX PULMONARY REFERRAL
PULMONARY & CRITICAL CARE CONSULTANTS, INC.

Main Location
1520 S. MAIN ST. SUITE 2
DAYTON, OHIO 45409
PHONE: 937-461-5815

MVH South (Satellite)
2300 Miami Valley Dr. #370
Centerville, OH 45459
FAX: 937-461-2896
WWW.PULMCARE.COM

UVMC Location
3130 N. Co Rd 25A
Suite 203
Troy, OH 45373
Phone: 937-552-7038
Fax: 937-552-9436

Please complete form and fax reports listed below to expedite scheduling

Date ________________

Patient ____ DOB ___________________________

Address ________________________________Apt # _______ City ________________________ Zip _________

Insurance ____ID# ____________________________
Please fax referral or authorization if required.

Home phone ____________________ Work phone _______________________ Cell phone _________________

Requesting Dr. ________________ Phone _________________ Fax _________________ Contact ______________

Please indicate preference:

First available/No preference ______
James J. Murphy, MD, FCCP ______
M. Mazen Dallal, MD, FCCP, D, ABSM ______
Thomas J. Donnelly, MD, FCCP ______
Dharmesh V. Gandhi, MD, FCCP, D, ABSM ______
Steven L. Chambers, MD, FCCP ______

Murthy V. Gollamudi, MD, FCCP, D, ABSM ______
Jennifer K. Clune, MD ______
Gabriel J. Hays, DO ______
Emily Speelmon, MD, PhD ______
Soumitra Sen, MD ______

Reason for referral ____
(Please fax: PFT's, CXR's, CT chest, Echo, Stress, EKG, Labs, Last 3 office notes, & anything else useful)

∗We will contact your patient to schedule and notify your office∗

OFFICE USE ONLY

Scheduled with ______________________________ Appt. Date/Time/Arrival ______________________________

Previous Testing
CXR ______________________________ LOC ________________________Date called _____________
CT ______________________________ LOC ________________________Date called _____________

PFT ______________________________ LOC _______________________ Date called_____________
MCT ______________________________ LOC ________________________Date called _____________

ECHO ______________________________ LOC ________________________Date called _____________
STRESS ______________________________ LOC ________________________Date called _____________

SLEEP TESTING _____________________ LOC ________________________Date called _____________

Medical History ____

Previous Admit ____

Office Testing CXR PFT PFT P/P EX OX – RA / 02

Faxed ___________ Mailed _____________ Online _____________ Copied _______________ Initials _________