# THE DAYTON RESPIRATORY CENTER

**www.dayresp.com**

# REFERRAL FORM

***THANK YOU FOR CHOOSING US AS YOUR PREFERRED PULMONARY & SLEEP MEDICINE PROVIDERS***

***PLEASE CIRCLE PHYSICIAN IF APPLICABLE***

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|---|---|---|
| **Rajesh C. Patel, MD, FCCP, DABSM** | **Anuj Goyal, MD, FCCP, DABSM** | **Thomas M. Yunger, MD, FCCP, DABSM** |
| **Ellen B. Pacia, MD, FCCP** | **Patrick F. Allan, MD, FOCP, DABSM** | **Priyanka Jain, MD** |
| **Junaid Malik M.D** | **Timothy Hwalek, MD** | **Dr Michael Bann, MD** |
| **Jason Wannemacher, APRN-CNP** | **Nicole Epard, APRN-CNP** | **Julie Lurie APRN-CNP** |
| **Erin Radominski, APRN-CNP** | **Kearston Beckett-Taylor, APRN-NP** | **Christina Handermann, APRN-CNP** |
| **Jennifer Long APRN-CNP** | **Chelsea Miller APRN-CNP** | **First Available** |

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**MAIN LOCATIONS**

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|---|---|---|---|
| 9001 N Main Street<br>Dayton Ohio 45414<br>937-832-0990<br>933-832-7323 - Fax | 7415 Brandt Pike<br>Huber Heights Oh 45424<br>937-610-3800<br>937-610-4680 - Fax | 7056 Corporate Way<br>Centerville Oh 45459<br>937-312-9144<br>937-312-9146 - Fax | 200 Medical Center Dr<br>ST 290, Middletown Oh<br>513-857-3301<br>513-949-6100 - Fax |

**SATELLITE OFFICES**

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|---|---|---|
| 700 S. Stanfield<br>Troy Ohio 45373<br>Every other Thursday 1pm - 3 pm<br>Dr. Allan<br>937-832-0990<br>937-832-7323- Fax | 1244 Meadow Bridge Drive<br>Beavercreek Ohio 45434<br>Monday Morning 8am - 11am<br>Dr. Goyal & Jason CNP<br>937-610-3800<br>937-610-4680- Fax | 30 w McCreight Ave<br>St 100 - Entrance B<br>Springfield Ohio 45504<br>Thursday availability<br>Dr Yunger, Dr Allan & Chelsea M<br>937-610-3800 |

Date:_____

Referring Physician:_____

Physician's Address:_____

Contact:_____Phone:_____Fax:_____

Diagnosis:_____

**** TO PREVENT A DELAY IN THE PATIENT BEING SCHEDULED PLEASE SEND A COPY OF INSURANCE CARDS, ANY REPORTS OF CHEST CT SCANS, CXRS, PFTS, AND SLEEP STUDIES WITH PAP COMPLIANCE REPORTS IF AVAILABLE ****

**Patient Information:**

First Name:_____Last Name:_____MI:_____

Address:_____

City, State, Zip:_____

Phone:_____Work/Cell:_____

D.O.B.:_____ **(Please Circle)** Male/Female

**Please check the reason for referral:**

- ☐ PULMONARY FUNCTION TEST ONLY- NO APPT WITH DR/NP
- ☐ PULMONARY CONSULTATION
- ☐ SLEEP CONSULTATION