

# Referral Form

## Hematology & Oncology

**Atrium Medical Center**

501 Atrium Dr.  
 Franklin, OH 45005

- First Available
- Nkeiruka Okoye, MD
- Radhika Rajsheker, MD
- Mridula P. Reddy, MD

**Greater Dayton Cancer Center**

3120 Governor's Place Blvd.  
 Kettering, OH 45409

- First Available
- Charles Bane, MD
- Satheesh Kathula, MD, FACP
- Mark Marinella, MD, FACP
- Mark Romer, MD
- Tarek Sabagh, MD, FACP
- James Sabiers, MD
- Ketan Shah, MD
- Manish Sheth, MD
- Burhan Yanes, MD

**Miami Valley Hospital North**

9000 N. Main St., Ste. G-37  
 Dayton, OH 45415

- First Available
- Charles Bane, MD
- Howard Gross, MD, FACP
- Shamim Jilani, MD, FACP
- Jhansi Koduri, MD
- Mark Marinella, MD, FACP
- Kelly Miller, MD, PhD
- Tarek Sabagh, MD, FACP
- Ketan Shah, MD
- James Sabiers, MD

**Miami Valley Hospital South**

2300 Miami Valley Dr. Suite 150  
 Centerville, OH 45459

- First Available
- Satheesh Kathula, MD, FACP
- Jhansi Koduri, MD
- Mark Marinella, MD, FACP
- Mridula P. Reddy, MD
- Mark Romer, MD
- Tarek Sabagh, MD, FACP
- James Sabiers, MD
- Burhan Yanes, MD

**Upper Valley Medical Oncology**

3130 N. Dixie Highway, Suite 107  
 Troy, OH 45373

- First Available
- Rajeev Kulkarni, MD
- Mohan Nuthakki, MD

**Wayne Cancer Center**

1111 Sweitzer St.  
 Greenville, OH 45331

- First Available
- Kelly Miller, MD, PhD
- Manish Sheth, MD

**Wilson Memorial Hospital**

915 West Michigan St.  
 Yager Building  
 Sidney, OH 45365

- First Available
- Rajeev Kulkarni, MD

**Date:** \_\_\_\_\_

**Patient Information:**

**Name** \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Last 4 Digits of Patient's SS \_\_\_\_\_

Language Spoken \_\_\_\_\_ Hearing Impaired  Yes  No

Insurance \_\_\_\_\_

\*Please send copy of insurance card.

**Contact Information if Different From Above:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

**Referral Information:**

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ Scheduler Name \_\_\_\_\_

**Reason for Referral/Diagnosis:** \_\_\_\_\_

Urgent  2<sup>nd</sup> Opinion  Previous XRT? \_\_\_\_\_  Routine

**Please Fax/Email Most Recent Pertinent Records**

Pathology reports  Radiology reports  Blood work  Progress notes  Copy of current insurance card

**Dayton Physicians will be happy to contact the patient and notify your office when the appointment is scheduled**

Yes  No

**Please provide more information about Dayton Physicians Network**

Yes  No

**Direct Referrals To:**

Phone:

(937) 245-6333

Fax:

(937) 245-6336

Email: [referrals@daytonphysicians.com](mailto:referrals@daytonphysicians.com)

**For Office Use Only:**

Appointment Date \_\_\_\_\_ Time \_\_\_\_\_

Physician \_\_\_\_\_ Location \_\_\_\_\_