

**Hand and  
Reconstructive  
Surgeons, Inc.**

2350 MIAMI VALLEY DRIVE  
SUITE 310  
DAYTON, OHIO 45459  
(937) 435-HAND (4263)  
800-750-9401

# Scheduling Form



Fax to: 937-298-9459

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

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

Daytime Phone # \_\_\_\_\_ Evening Phone # (After 6 pm) \_\_\_\_\_  
Home/Work/Cell Home/Work/Cell

Referring Dr. \_\_\_\_\_ Fax \_\_\_\_\_ Phone \_\_\_\_\_

Person completing form: \_\_\_\_\_

**First Available Provider**

Peter S. Barre, M.D. \_\_\_\_\_  
Beth A. Berrettoni, M.D. \_\_\_\_\_  
Christopher J. Danis, M.D. \_\_\_\_\_  
Rannie AlSamkari, M.D. \_\_\_\_\_  
Karen L. Storer, PA-C \_\_\_\_\_

**PLEASE FAX ALL PERTINENT TEST RESULTS. Faxed:**  Yes  No

\_\_\_ X-Rays - Send Films      \_\_\_ Labs - Send Report  
\_\_\_ MRI - Send Films and Report      \_\_\_ EMG - Send Report

Diagnosis: \_\_\_\_\_

Due to auto accident:      \_\_\_ Yes \_\_\_ No      Worker's Comp      \_\_\_ Yes \_\_\_ No

Claim # \_\_\_\_\_ SS# \_\_\_\_\_ MCO/SI \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Insurance: \_\_\_\_\_

## Hand and Reconstructive Surgeons Staff Will Complete

Date: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

Scheduled with: \_\_\_\_\_ Appt. Location: \_\_\_\_\_

Test Results Received: \_\_\_\_\_ Yes \_\_\_\_\_ No

Date Faxed to referring Dr.: \_\_\_\_\_

Scheduler: \_\_\_\_\_

### Locations

**Miami Valley South • Tipp City • Middletown • Englewood**