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phone 559.272.1680 fax 559.432.8586

REFERRAL FORM

Patient Appointment Date ________________ **Time** ________am/pm

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ______________________________

Home Phone: ______________________________ Caregiver Phone: ______________________________

Cell Phone: ______________________________ SS#: ______________________________

REFERRING PHYSICIAN INFORMATION

Referring Physician (Print): ______________________________ Phone: ______________________________

Practice Contact: ______________________________ Fax: ______________________________

Practice Address: ______________________________

______________________________ Primary Care Physician (Print): ______________________________

Date of patients next appt. with referring M.D.: ______________________________ Urgency: ☐ Stat ☐ Routine

CLINICAL INFORMATION

Reason for Consultation: ____

Symptoms/Diagnosis: ____

____

SCHEDULING INFORMATION

Interventional Radiologist Preference: Y / N ______________________________ Interpreter Needed? Language: Y / N ______________________________

Please fax this completed form to 559.432.8586 and kindly include:

- ✓ Demographic sheet with patient address and insurance information and/or copy of insurance card.
- ✓ Recent/Relevant typed clinical notes/test results, i.e. History & Physical, Ultrasound/MRI/CT/X-ray & Lab results.

Our staff will contact your patient to schedule the appointment and then notify your office.

____

Referring Physician Signature *(required)* *Date*