FAX REFERRAL REQUEST

University | Neurosciences Institute

Affiliated with UCSF
School of Medicine
Fresno Medical Education Program
A member of the Community Foundation Medical Group
part of the Santé Health Foundation

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www.UniversityMDs.com

Referrals can be made by faxing this form or calling the office.

Date: ______________________ Number of Pages: ______________

☐ **Derek Taggard, M.D.** ☐ **Nicholas Levine, M.D.**

REQUIRED PATIENT INFORMATION

- ☐ Santé Referral
- ☐ Insurance Auth (Ex: TRICARE, Worker's Comp, etc.)
- ☐ Worker's Compensation (Claim Number, Date of Injury, Adjuster/NCM Name and Contact Info)
- ☐ Copy of Insurance Card/Demographic Sheet
- ☐ Last Chart Notes
- ☐ Last Physical Therapy Note if Completed
- ☐ Last Pain Management Note if Completed
- ☐ EMG/NCV Report if Completed
- ☐ Neurology Consult Report if Completed
- ☐ Patient's Height
- ☐ Patient's Weight
- ☐ MRI/CT Done in the Last 6 Months

Protocol for Brain Tumors: For any brain tumors that may be compromising the patients vision, visual field tests should be ordered/completed prior to appointment scheduling.
Protocol for Pituitary Tumors: Patients with this diagnosis should complete the following labs prior to appointment scheduling: prolactin, electrolytes, TSH, T4, ACTH, cortisol, urine cortisol and IGF1.

****NOTE All information and radiology images are needed to schedule an appointment.**

Referring Physician: ______________________ Phone: ______________

PCP (if different from referring): ______________________ Phone: ______________

Patient Name: ______________________

Patient Home Phone: ______________________ Patient Cell: ______________

Consultation for: ______________________

Diagnosis: ______________________

Insurance: ______________________

IMPORTANT INFORMATION

Office Policy states that any imaging that was not performed at Advanced Medical Imaging, California Imaging, CRMC, Clovis Community or Sierra Imaging must be hand carried by patient to their appointment.

Images, related to the diagnosis, must have been taken within 6 months of the referral. Insurance authorization must also be sent with the referral.

Contact Person: ______________________ Title: ______________

Phone: ______________________ Fax: ______________

Comments: ______________________

Thank you very much for referring your patient to our office.
Additional questions, please contact our Referrals Department at 559.256.9622

* INTERNAL USE ONLY *

Appointment Date: ______________ Time: ______________ Contact Person: ______________

Fax Referrals to Sylvia at 559.256.4432