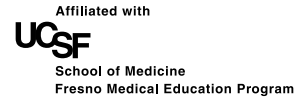


FAX REFERRAL REQUEST

University | Sleep and Pulmonary Associates



6733 N. Willow Ave., Suite 107, Fresno, CA 93710
Phone: 559.435.4700 · Fax: 559.298.7951
www.UniversityMDs.com

Date: \_\_\_\_\_ Number of Pages: \_\_\_\_\_

- First Available Physician Eyad Almasri, M.D. Karl Van Gundy, M.D.
David Lee, M.D. Rafael Zuzuarregui, M.D.
Pulmonary Fellow with Attending Physician

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Home Phone: \_\_\_\_\_ Patient Cell: \_\_\_\_\_

Diagnosis (required): \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax : \_\_\_\_\_

PCP (if different from referring): \_\_\_\_\_

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

REQUIRED PATIENT INFORMATION

- Copy of referral
Must include HMO referral for appointment to be scheduled.
Copy of patient insurance card and demographics
Copy of last chart notes, H & P
Copy of last 2 chest x-ray/CT reports (must have at least 1)
Copy of medication list
Copy of Pulmonary Function Test/Spirometry/ECHO

NOTE: All information is needed to schedule an appointment.

The patient must HAND CARRY the FILMS or DISK of their chest x-ray/CT if not, the patient will have to be rescheduled.

REFERRING PROVIDER MUST NOTIFY PATIENTS OF APPOINTMENT AND X-RAY/CT INSTRUCTIONS.

Thank you very much for referring your patient to our office!

OFFICE USE ONLY:

Appointment Date at UNMSC: \_\_\_\_\_ Time: \_\_\_\_\_ with Dr.: \_\_\_\_\_