FAX REFERRAL REQUEST

University | Rheumatology Associates

Affiliated with UCSF School of Medicine

2335 East Kashian Lane, Suite 301 · Fresno, CA 93701
Phone: 559.256.9690 · Fax: 559.256.9691
www.UniversityMDs.com

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

Date: _____ Number of Pages: _____

☐ Shefali Majmudar, D.O. ☐ Candice Yuvienco, M.D., RhMSUS

☐ *Next Available Physician*

Referring Physician: _____ Phone: _____

PCP (if different from referring): _____

Patient Name: _____

Patient Home Phone: _____ Patient Cell: _____

Consultation For: _____

Diagnosis (required): _____

_____

REQUIRED PATIENT INFORMATION

☐ HMO Referral
☐ Copy of patient insurance card and demographics
☐ Copy of last chart notes, H&P
☐ Copy of most recent lab results and imaging studies

*****NOTE: All information is needed to schedule an appointment.

Special instructions: _____

_____

Contact person: _____ Title: _____

Email: _____

Phone: _____ Fax: _____

Appointment Date at URA: _____ Time: _____ Contact Person: _____

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