

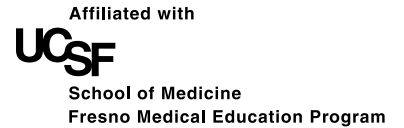
FAX REFERRAL REQUEST

University | Specialty Surgery Associates

2335 E. Kashian Lane, Suite 220 · Fresno, CA 93701

Phone: 559.256.5140 · Fax: 559.485.4505

www.UniversityMDs.com



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

Date: _____ Number of Pages: _____

- First Available Physician, Babak Eghbalieh, M.D., Amir Fathi, M.D. (with specialties)

Referring Physician: _____ Phone: _____

PCP (if different from referring): _____

Patient Name: _____

Patient Home Phone: _____ Patient Cell: _____

Consultation For: _____

Diagnosis (required): _____

REQUIRED PATIENT INFORMATION

- Copy of referral, Copy of patient insurance card and demographics, Copy of last chart notes, Copy of lab reports, Films requested from: _____ for delivery to University Specialty Surgery Associates, 2335 E. Kashian Lane, Suite 220, 93701

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

Special instructions: _____

Contact person: _____ Title: _____

Phone: _____ Fax: _____

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

***** INTERNAL USE ONLY *****

Appointment Date: _____ Time: _____ Contact Person: _____