FAX REFERRAL REQUEST

University | Sleep and Pulmonary Associates

Affiliated with UCSF School of Medicine

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.
☐ David Lee, M.D. ☐ Karl Van Gundy, 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.: _____