FAX REFERRAL REQUEST

University | Oncology Associates

Affiliated with UCSF School of Medicine

2335 East Kashian Lane, Suite 301 · Fresno, CA 93701
Phone: 559.459.4662 · Fax: 559.459.4699
www.UniversityMDs.com

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

Date: _____ Number of Pages: _____

☐ Haifaa Abdulhaq, M.D. ☐ Uzair Chaudhary, M.D.
☐ Vajeeha Tabassum, M.D. ☐ Omid Saeed-Tehrani, M.D., Ph.D.
☐ *First Available Physician*

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, H & P
☐ Copy of pathology reports(s)
☐ Copy of most recent lab results and imaging studies

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

Special instructions: _____

_____

Contact person: _____ Title: _____

Phone: _____ Fax: _____

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

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