Hillblom Center on Aging

A University Center of Excellence

Affiliated with UCSF School of Medicine Fresno Medical Education Program

FAX REFERRAL REQUEST

2335 E. Kashian Lane, Suite 301 · Fresno, CA 93701

Phone: 559.443.2684 · Fax: 559.264.9199

www.UniversityMDs.com

Date: ______________________ Number of Pages: ______________________

☐ **Walter A. Forred, M.D.**
Director, Hillblom Center on Aging, UCSF Fresno

Referring Physician: ______________________ Phone: ______________________

PCP (if different from referring): ______________________ Phone: ______________________

Patient Name: ______________________ DOB: ______________________

Referring DX: ______________________

REASON FOR REFERRAL:

- ☐ Functional decline
- ☐ Failure to thrive/cope
- ☐ Falls/Mobility problems
- ☐ Frailty
- ☐ Confusion
- ☐ Medication review/Polypharmacy
- ☐ Incontinence
- ☐ Caregiver burnout
- ☐ Multiple office visits secondary to issues of aging

REQUIRED PATIENT INFORMATION

- ☐ Patient Demographics
- ☐ HMO Referral/Authorization
- ☐ Copy of Insurance Card
- ☐ Chart Notes pertaining to diagnosis
- ☐ Patient labs performed within the past 12 months
- ☐ MRI, MRA and CT reports and images preformed within the last 12 months.
- ☐ Chart notes for all previous physicians
- ☐ Films requested from:

*******Please note: All of the required information is necessary to process this referral, failure to provide adequate clinicals could delay the scheduling process.**

Additional Instructions (Request for interpreter, additional special needs, etc.):

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Contact person: ______________________ Title: ______________________

Email: ______________________

Phone: ______________________ Fax: ______________________

We will contact your patient for scheduling.

Internal Use Only ....

Appointment Date: ______________ Time: __________ Contact Person: ______________

Your patient has been contacted and is aware of this appointment. Thank you for your referral!