# FAX REFERRAL REQUEST


University | Oncology Associates

Affiliated with UCSF School of Medicine Fresno Medical Education Program

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*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. ☐ Erica Castillo, NP-C
☐ Li Li, M.D., Ph.D. ☐ Mohammed Sani Bukari, M.D.
☐ *First Available Physician* ☐ Constance Stoehr, M.D.

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!*