FAX REFERRAL REQUEST

DEAP Diabetes Education Accreditation Program — AADE American Association of Diabetes Educators

University | Diabetes and Endocrine Specialists

Affiliated with UCSF School of Medicine Fresno Medical Education Program

7085 N. Chestnut Ave., Suite 101 - Fresno, CA 93720
Phone: 559.323.9236 · Fax: 559.323.0294
UniversityMDs.com

Date: _____ Number of Pages: _____

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☐ April Herd PA-C ☐ Jaspreet Riar PA-C

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) (*If Applicable)*
☐ Copy of medication list
☐ Copy of Pulmonary Function Test/Spirometry/ECHO (*If Applicable)*

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 UDES: _____ Time: _____ with Dr.: _____