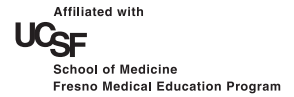


FAX REFERRAL REQUEST



University | Diabetes and Endocrine Specialists



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

Date: _____ Number of Pages: _____

- Varsha Babu, M.D. Panchali Khanna, M.D. Shreela Mishra, M.D.
- Raymundo Punzalan, M.D. Ngwe Yin, M.D.
- 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.: _____