FAX REFERRAL REQUEST

University | Psychiatry Associates

Affiliated with UCSF School of Medicine
Fresno Medical Education Program

2210 E. Illinois Avenue, Suite 401 · Fresno, CA 93701
Phone: 559.320.0580 · Fax: 559.320.0582

www.UniversityMDs.com

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

Date: _____ Number of Pages: _____

- ☐ Craig Campbell, M.D.
- ☐ Karen Kraus, M.D.
  Child & Adolescent Psychiatry
- ☐ Andrew Goddard, M.D.
- ☐ Liao, Betty, PhD
- ☐ *First Available Physician*

Referring Physician: _____ Contact Person: _____

Phone: _____ Fax: _____

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

Patient Name: _____ DOB: _____

Patient Home Phone: _____ Patient Cell: _____

Diagnosis: _____

Insurance: _____

Please fax referral, medical records, labs, demographics, insurance card (front and back), and prior authorization (if required) to 559.320.0582.

Please have patient call us to schedule an appointment at 559.320.0580.

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

* INTERNAL USE ONLY *

Appointment Date: _____ Time: _____ Contact Person: Lisa Gonzales