FAX REFERRAL REQUEST

University | Neurosciences Institute - Visalia

Affiliated with UCSF School of Medicine Fresno Medical Education Program

A member of the Community Foundation Medical Group part of the Santé Health Foundation

5410 W. Cypress Ave, Suite #102 • Visalia, CA 93277

Phone: 559.320.0530 · Fax: 559.320.0532

www.UniversityMDs.com

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

Date: _____ Number of Pages: _____

☐ Nathan Deis, M.D., MSc, FRCSC ☐ Yu-Hung Kuo, M.D., Ph.D.

Physicians are a member of the Community Foundation Medical Group part of the Santé Health Foundation

REQUIRED PATIENT INFORMATION

- ☐ Santé Referral
- ☐ Insurance Auth (Ex: TRICARE, Worker's Comp, etc.)
- ☐ Worker's Compensation (Claim Number, Date of Injury, Adjuster/NCM Name and Contact Info)
- ☐ Copy of Insurance Card/Demographic Sheet
- ☐ Last Chart Notes
- ☐ Last Physical Therapy Note if Completed
- ☐ Last Pain Management Note if Completed
- ☐ EMG/NCV Report if Completed
- ☐ Neurology Consult Report if Completed
- ☐ Patient's Height
- ☐ Patient's Weight
- ☐ MRI/CT Done in the Last 6 Months

Protocol for Brain Tumors: For any brain tumors that may be compromising the patients vision, visual field tests should be ordered/completed prior to appointment scheduling.
Protocol for Pituitary Tumors: Patients with this diagnosis should complete the following labs prior to appointment scheduling: prolactin, electrolytes, TSH, T4, ACTH, cortisol, urine cortisol and IGF1.

****NOTE All information and radiology images are needed to schedule an appointment.**

Referring Physician: _____ Phone: _____

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

Patient Name: _____

Patient Home Phone: _____ Patient Cell: _____

Consultation for: _____

Diagnosis: _____

Insurance: _____

IMPORTANT INFORMATION

Office Policy states that any imaging that was not performed at Advanced Medical Imaging, California Imaging, CRMC, Clovis Community or Sierra Imaging must be hand carried by patient to their appointment.

Images, related to the diagnosis, must have been taken within 6 months of the referral. Insurance authorization must also be sent with the referral.

Contact Person: _____ Title: _____

Phone: _____ Fax: _____

Comments: _____

Thank you very much for referring your patient to our office.
Additional questions, please contact our Referrals Department at 559.256.9622 or fax referrals to 559.256.4432

* INTERNAL USE ONLY *

Appointment Date: _____ Time: _____ Contact Person: _____