FAX REFERRAL REQUEST

University | Gastroenterology & Hepatology Associates

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Affiliated with
UCSF
School of Medicine
Fresno Medical Education Program

Date: _____ Number of Pages: _____

☐ *Marina Roytman, M.D.*
Hepatology

☐ *Thimmaiah Theethira, M.D.*
IM/GI

Date physician would like patient to be seen: _____

REQUIRED PATIENT INFORMATION

☐ Demographics/Insurance
☐ Procedure Report(s) (EGD, Colon, EUS, etc.)
☐ Imaging/Scans (CT, MRI, US)
☐ Labs
☐ Pathology

******NOTE: All information is needed to schedule an appointment.

Referring Physician: _____ Phone: _____

PCP (if different from referring): _____

Patient Name: _____ DOB: _____

Patient Home Phone: _____ Cell: _____ Work: _____

Consultation For: _____

Diagnosis (required):_____

_____

Contact person: _____ Title: _____

Phone: _____ Fax: _____

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