

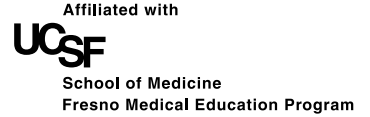
FAX REFERRAL REQUEST

University | Gastroenterology & Hepatology Associates

2335 E. Kashian Lane, Suite 260 · Fresno, CA 93701

Phone: 559.256.5136 · Fax: 559.485.4504

UniversityMDs.com



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!*