

FAX REFERRAL REQUEST
University | Neurosciences Institute

Affiliated with
UCSF
School of Medicine
Fresno Medical Education Program
A member of the Community Foundation Medical Group
part of the Santé Health Foundation

45 River Park Place West, Suite 104 · Fresno, CA 93720
Phone: 559.320.0530 · Fax: 559.320.0532

UniversityMDs.com

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

Date: _____ Number of Pages: _____

- | | |
|--|---|
| <input type="checkbox"/> Nathan Deis, MD | <input type="checkbox"/> Nicholas Levine, MD |
| <input type="checkbox"/> Samia Ghaffar, MD | <input type="checkbox"/> Robert Macdonald, MD |
| <input type="checkbox"/> Amir Khan, MD | <input type="checkbox"/> Derek Taggard, MD |
| <input type="checkbox"/> Yu-Hung Kuo, MD | <input type="checkbox"/> <i>First Available Physician</i> |

REQUIRED PATIENT INFORMATION

- | | |
|---|---|
| <input type="checkbox"/> Santé Referral | <input type="checkbox"/> Last Pain Management Note if Completed |
| <input type="checkbox"/> Insurance Auth (Ex: TRICARE, Worker's Comp, etc.) | <input type="checkbox"/> EMG/NCV Report if Completed |
| <input type="checkbox"/> Worker's Compensation (Claim Number, Date of Injury, Adjuster/NCM Name and Contact Info) | <input type="checkbox"/> Neurology Consult Report if Completed |
| <input type="checkbox"/> Copy of Insurance Card/Demographic Sheet | <input type="checkbox"/> Patient's Height |
| <input type="checkbox"/> Last Chart Notes | <input type="checkbox"/> Patient's Weight |
| <input type="checkbox"/> Last Physical Therapy Note if Completed | <input type="checkbox"/> 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

***** INTERNAL USE ONLY *****

Appointment Date: _____ Time: _____ Contact Person: _____

University Neurosciences Institute
45 River Park Place West, Suite 104, CA 93720
559.320.0530 // 559.320.0532 fax

We are located on the first floor of the University of Phoenix building next to the Fresno Heart & Surgical Hospital.

When traveling from the North:

Take the 41 Highway South and exit on Friant Ave. Take Friant Ave. East to North Fresno St. Make a left turn at North Fresno St and drive North until you come to a stop sign which will be River Park Place. Make a left at the stop sign and follow the road until you reach our location on your left hand side.

When traveling from the South:

Take the 41 Highway North and exit on Friant Ave. Take Friant Ave. East to North Fresno St. Make a left turn at North Fresno St and drive North until you come to a stop sign which will be River Park Place. Make a left at the stop sign and follow the road until you reach our location on your left hand side.

Monday Tuesday Wednesday Thursday Friday
_____ AM / PM

