

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

805 W. Acequia, Suite 2D • Visalia, CA 93291
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: \_\_\_\_\_

- Referral options: Nathan Deis, MD, MSc, FRCSC; Yu-Hung Kuo, MD, PhD; Derek A. Taggard, MD; Samia Ghaffar, MD; Robert Macdonald, MD; First Available Physician

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

REQUIRED PATIENT INFORMATION

- Checkboxes for patient info: Santé Referral, Insurance Auth, Worker's Compensation, Copy of Insurance Card, Last Chart Notes, Last Physical Therapy Note, Last Pain Management Note, EMG/NCV Report, Neurology Consult Report, 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: \_\_\_\_\_

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**Monday      Tuesday      Wednesday      Thursday      Friday**

\_\_\_\_\_ AM / PM

