**FAX REFERRAL REQUEST – (Clovis, and Visalia)**

**University Surgical Associates**

**CLOVIS** - 729 Medical Center Drive West, Suite 111 · Clovis, CA 93611  
**VISALIA** - 805 W. Acequia Ave, Suite 2D · Visalia, CA 93291

Phone: 559.435.6600 · Fax: 559.435.6622 · UniversityMDs.com

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

| First Available Physician | Christina Maser, MD  
Endocrine & General Surgery  
□ Clovis □ Visalia | Charlotte McFall, NP-C, MSN-FNP  
Vascular/Dialysis Access & General Surgery  
□ Clovis □ Visalia | WOUND CARE SERVICES  
Christopher Kinter, MD  
Vascular/Dialysis Access & General Surgery  
□ Clovis □ Visalia |
|---------------------------|---------------------------------|---------------------------------|---------------------|
| Christopher Kinter, MD  
Vascular/Dialysis Access & General Surgery  
□ Clovis □ Visalia | Farah Karipineni, MD  
Endocrine & General Surgery  
□ Clovis □ Visalia | Charlotte McFall, NP-C, MSN-FNP  
Vascular/Dialysis Access & General Surgery  
□ Clovis □ Visalia |

Referring Physician: ______________________________________ Phone: ____________________________

PCP (if different from referring): ____________________________

Patient Name: ____________________________________________

Patient Home Phone: ____________________________ Patient Cell: ____________________________

Consultation For: ________________________________________

Diagnosis (required): ______________________________________

**REQUIRED PATIENT INFORMATION**

- □ Copy of referral
- □ Copy of patient insurance card and demographics
- □ Copy of last chart notes
- □ Copy of lab reports
- □ Films requested from: ____________________________

for delivery to: University Surgical Associates, 729 Medical Center Drive West, Suite 111, Clovis, CA 93611

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

Special instructions: ______________________________________

Contact person: _________________________________________ Title: ____________________________

Phone: ____________________________ Fax: ____________________________

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

**INTERNAL USE ONLY**

Appointment Date: ____________________________ Time: ____________________________ Contact Person: ____________________________