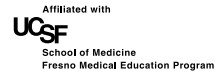


FAX REFERRAL REQUEST

University | Sleep and Pulmonary Associates

6733 N. Willow Ave., Suite 107 · Fresno, CA 93710
Phone: 559.435.4700 · Fax: 559.298.7951
UniversityMDs.com



Date: \_\_\_\_\_ Number of Pages: \_\_\_\_\_

- First Available Physician, Eyad Almasri, MD, Caterina Mosti, PhD, Pulmonary Fellow with Attending Physician, Mohamed Fayed, MD, Karl Van Gundy, MD, David W. Lee, MD

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Home Phone: \_\_\_\_\_ Patient Cell: \_\_\_\_\_

Diagnosis (required): \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax : \_\_\_\_\_

PCP (if different from referring): \_\_\_\_\_

Insurance: \_\_\_\_\_

REQUIRED PATIENT INFORMATION

- Copy of referral (Must include HMO referral for appointment to be scheduled), Copy of patient insurance card and demographics, Copy of last chart notes, H & P, Copy of last 2 chest x-ray/CT reports (must have at least 1), Copy of medication list, Copy of Pulmonary Function Test/Spirometry/ECHO

NOTE: All information is needed to schedule an appointment.

The patient must HAND CARRY the FILMS or DISK of their chest x-ray/CT if not, the patient will have to be rescheduled.

REFERRING PROVIDER MUST NOTIFY PATIENTS OF APPOINTMENT AND X-RAY/CT INSTRUCTIONS.

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

OFFICE USE ONLY:

Appointment Date at UNMSC: \_\_\_\_\_ Time: \_\_\_\_\_ with Dr.: \_\_\_\_\_