University | Orthopaedic Associates

Affiliated with UCSF
School of Medicine
Fresno Medical Education Program

604 N Magnolia, Suite 100,
Clovis, CA 93611

Phone 559.320.0531
Referrals
Fax 559.320.0539

UniversityMDs.com

FAX REFERRAL REQUEST • Referrals can be made by faxing this form or calling the office.

- ☐ **Deniz Baysal, MD, FRCSC**
  Hip, Knee, Shoulder Replacements
  Revisions
- ☐ **Maximino Brambila, MD, MBA,**
  Wrist, Hand, and Upper Extremity
- ☐ **Jason Davis, MD**
  Orthopaedic Surgery
  Orthopaedic Trauma
- ☐ **Nathan Hoekzema, MD**
  Orthopaedic Surgery, Hand, Elbow,
  and Upper Extremity. Fracture Care
- ☐ **Robert Kollmorgen, DO**
  Hip Preservation and Sports Medicine
  Specialist
- ☐ **Eric Lindvall, DO**
  Post Traumatic Reconstruction/Traumatology
  Pediatric & Adult Fracture care
- ☐ **Armen Martirosian, MD**
  Orthopaedic Trauma
  Fracture Care
- ☐ **First Available Physician**
- ☐ **Mark Ayoub, MD***
  Orthopaedic Trauma
  Fracture Care
- ☐ **Michael D. Charles, MD***
  Elbow and Shoulder Specialist
- ☐ **Arbi Nazarian, MD***
  Hip and Knee Reconstruction & Revisions
- ☐ **Motasem Refaat, MD***
  Orthopaedic Trauma
  Fracture Care
- ☐ **John Wiemann, MD***
  Pediatric Orthopaedic Surgery

* A member of the Community Foundation Medical Group part of the Santé Health Foundation

Date: _____ Number of Pages: _____

Referring Physician: _____ Phone: _____

PCP (if different from referring): _____ Phone: _____

Patient Name: _____ DOB: _____

Consultation For: _____

Diagnosis: _____

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

- ☐ Copy of Referral
- ☐ Copy of Insurance Card/Demo Sheet
- ☐ Last Chart Notes
- ☐ Copy of Lab Results
- ☐ X-Ray/Ultrasound Reports
- ☐ Films requested from: _____
  for delivery to:
  604 N Magnolia, Suite 100
  Clovis, CA 93611

Special Instructions: _____

Contact person: _____ Title: _____

Phone: _____ Fax: _____ Comments: _____

INTERNAL USE ONLY .....

Appointment Date: _____ Time: _____ Contact Person: _____

☐ Office Notified ☐ Patient Notified Initials _____

Workers Compensation Referral Please Fax To: 559.320.0539

08.22.19