FAX REFERRAL REQUEST

University | Gastroenterology & Hepatology Associates

In affiliation with UCSF Fresno

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Date: _____ Number of Pages: _____

☐ *Adnan Ameer, MD*
GI

☐ *Thimmaiah Theethira, MD, DM*
IM/GI

☐ *Marina Roytman, MD*
Hepatology

☐ *Jayakrishna Chintanaboina, MD, MPH, FACP*
GI

☐ *Devon Kiker, MS, NP-C*

REQUIRED PATIENT INFORMATION

☐ Demographics/Insurance
☐ Procedure Report(s) (EGD, Colon, EUS, etc.)
☐ Imaging/Scans (CT, MRI, US)
☐ Labs
☐ Pathology

☐ Inflammatory Bowel Disease
☐ Second Opinion

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

Referring Physician: _____ Phone: _____

PCP (if different from referring): _____

Patient Name: _____ DOB: _____

Patient Home Phone: _____ Cell: _____ Work: _____

Consultation For: _____

Diagnosis (required): _____

Is the Patient Pregnant? (☐ YES ☐ NO)

Contact Person: _____ Title: _____

Phone: _____ Fax: _____

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