

FAX REFERRAL REQUEST

University

Gastroenterology & Hepatology Associates

In affiliation with UCSF Fresno

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UniversityMDs.com

Date: _____ Number of Pages: _____

Adnan Ameer, MD
GI

Jayakrishna Chintanaboina, MD, MPH, FACP
GI

Marina Roytman, MD
Hepatology

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!