# FAX REFERRAL REQUEST

University | Sleep and Pulmonary Associates

In affiliation with UCSF Fresno

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*

☐ Pulmonary Fellow with Attending Physician

☐ Eyad Almasri, MD

☐ Mohamed Fayed, MD

☐ David W. Lee, MD, FCCP

☐ Caterina Mosti, PhD

☐ Karl Van Gundy, 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.: _____