

FAX REFERRAL REQUEST

University | Sleep and Pulmonary Associates

In affiliation with UCSF Fresno

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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

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, 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.: _____