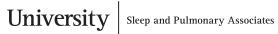
FAX REFERRAL REQUEST



In affiliation with UCSF Fresno

6733 N. Willow Ave., Suite 107 Fresno, CA 93710

Phone: 559.435.4700 | Fax: 559.298.7951

| Date: | _ | |
|--|--|---|
| Patient Demographics | | |
| Patient Name: | DOB: | ☐ Male ☐ Female |
| Language: Home Phone: | Cell Phone: | |
| Insurance: | | |
| Diagnosis (required): | | |
| Referring Physician: | | |
| Phone: | | |
| PCP (if different from referring): | | |
| Allergies: (please list) | | |
| Reason for Referral | | |
| Sleep Medicine Referral First Available Physician Eyad Almasri, MD Lynn Keenan, MD, FAASM Hovig Artinian, MD, MAT, FAAP Karl Van Gundy, MD, FACP Required Patient Information NOTE: All information is needed to schedule an appointment. HMO referral Patient information and demographics Medicine list Most recent chart notes and lab results Most recent sleep study if done in last year Appointment Update (USPA Staff Use Only) | Pulmonary Referral First Available Physician Eyad Almasri, MD Hovig Artinian, MD, MAT, FAAP Karl Van Gundy, MD, FACP Required Patient Information NOTE: All information is needed to so the second secon | raphics results (must have at least 1) est/Spirometry Only of the Community Medical ical Imaging, or California st X-ray/CT MUST be |
| Appointment Date at USPA: Time: | with Dr: | |