

In affiliation with UCSF Fresno

FAX REFERRAL REQUEST • Referrals can be made by faxing this form or calling the office

- | | | |
|--|--|---|
| <input type="checkbox"/> <i>First Available Physician</i> | <input type="checkbox"/> Jason Davis, MD
Orthopaedic Surgery and Orthopaedic Trauma | <input type="checkbox"/> Arbi Nazarian, MD
Hip and Knee Replacement and Revisions |
| <input type="checkbox"/> Raj M. Amin, MD
Hip and Knee Replacement and Revisions,
and Orthopaedic Shoulder Care | <input type="checkbox"/> Nathan Hoekzema, MD
Orthopaedic Surgery, Hand, Elbow,
and Upper Extremity. Fracture Care | <input type="checkbox"/> Motasem Refaat, MD
Orthopaedic Trauma Fracture Care |
| <input type="checkbox"/> Mark Ayoub, MD
Orthopaedic Trauma Fracture Care | <input type="checkbox"/> Robert Kollmorgen, DO
Hip Preservation and Sports Medicine
Specialist | <input type="checkbox"/> Geoffrey Rohlfing, DO
Hip and Knee Replacement and Revisions |
| <input type="checkbox"/> Deniz Baysal, MD, FRCSC
Hip, Knee, Shoulder Replacements,
Sports Medicine Specialist, and Arthritis Care | <input type="checkbox"/> Eric Lindvall, DO
Post Traumatic Reconstruction/Traumatology
Pediatric and Adult Fracture care | <input type="checkbox"/> Lucas Seiler, MD
Hand Surgery |
| <input type="checkbox"/> Maximino Brambila, MD, MBA
Wrist, Hand, and Upper Extremity | <input type="checkbox"/> Armen Martirosian, MD
Orthopaedic Trauma Fracture Care | <input type="checkbox"/> John Wiemann, MD
Pediatric Orthopaedic Surgery |

Date: _____

Referring Physician: _____ Phone: _____

PCP (if different from referring): _____ Phone: _____

Patient Name: _____ DOB: _____

Consultation For: _____

Diagnosis: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Copy of Referral | <input type="checkbox"/> Films requested from: _____ |
| <input type="checkbox"/> Copy of Insurance Card/Demo Sheet | |
| <input type="checkbox"/> Last Chart Notes | <i>For delivery to:</i> |
| <input type="checkbox"/> Copy of Lab Results | 604 N Magnolia, Suite 100 |
| <input type="checkbox"/> X-Ray/Ultrasound Reports | Clovis, CA 93611 |

Special Instructions: _____

Contact person: _____ Title: _____

Phone: _____ Fax: _____ Comments: _____

INTERNAL USE ONLY

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Appointment Date: _____ Time: _____ Contact Person: _____

Office Notified Patient Notified Initials _____

Workers Compensation Referral Please Fax To: 559.432.3025