

FAX - REFERRAL FORM

DATE REC'D _____

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PHONE: (559) 228-6600

CONSULTATION / REFERRAL REQUEST

1. REFERRED to _____ NEXT AVAILABLE PHYSICIAN OR Dr. _____

2. (Check one) CONSULT REFERRAL (USE MEDICARE DEFINITIONS)

3. Tentative Diagnosis/Reason for referral : _____

Referring Physician's Name _____

Address _____

Phone _____ FAX _____

E-mail _____

X _____
Signature Referring Physician

NPI# _____

UPIN# _____ LIC# _____

Internet Access: YES/NO

PATIENT INFORMATION

PATIENT INFORMATION

Name _____ M/F

Language Spoken _____ Nursing Home ? _____ Y N

Address _____

City _____ State _____ Zip _____

Hm. Phone _____ Alt Phone _____

SS# _____ DOB _____

INSURANCE INFORMATION

REFERRAL FROM PCP REQ'D Yes / No

PCP: _____

Primary Ins: _____

ID: _____

2nd Ins: _____

ID: _____

APPOINTMENT CONFIRMATION

Patient is scheduled on _____ at _____ with _____ M.D.

Scheduled with: (referring contact name): _____

By (FRESNO NEPHROLOGY contact person): _____

COMMENTS: **Please fax current labs (Metabolic Panel and CBC) and a copy of insurance cards.**

FAX COMPLETED FORM TO: (559) 228-6612

MEDICAL RECORDS AND INSURANCE CARDS ATTACHED