FAX REFERRAL REQUEST

Fax (559) 459-1539 | Referral Line (559) 459-BEAR (2327)

COMMUNITY REGIONAL MEDICAL CENTER

Pediatric Specialty Care, North Medical Plaza
215 North Fresno Street, Suite 370
Fresno, California 93701
Office: (559) 459-4543

COMMUNITY HEALTH PARTNERS

Community Pediatric Specialists
726 Medical Center Drive East, Suite 209
Clovis, California 93611
Office: (559) 325-5656

☐ **URGENT/STAT**

Date: _____ Number of Pages: ____

- ☐ Allergy
- ☐ Cardiology
- ☐ Cystic Fibrosis
- ☐ Endocrinology/Diabetes
- ☐ Gastroenterology
- ☐ Genetics
- ☐ Hematology
- ☐ Infectious Disease
- ☐ Nephrology
- ☐ Neurology
- ☐ Pulmonology/Asthma
- ☐ Rheumatology
- ☐ Surgery
- ☐ Ancillary Services (PFT, EKG, Echo)
- ☐ Other _____

Patient Name: _____ DOB: _____ Phone: _____

Diagnosis: _____

Reason For Visit: _____ Type of Insurance: _____

Referring Physician: _____ Phone: _____ Fax: _____

Referral Contact: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Additional Instructions (Request for interpreter, additional special needs, etc.):

_____

_____

PLEASE INCLUDE THE FOLLOWING DOCUMENTATION IF POSSIBLE

- ☐ Demographics sheet
- ☐ Insurance card(s) (front & back)
- ☐ Physician progress notes and labs
- ☐ Radiology reports including CT, MRI, ultrasound, x-ray, etc. (Please have patient bring a CD of radiology studies)

PLEASE NOTE

- Please allow our office 72 hours to respond. Appointments will be scheduled upon receiving completed request.
- We will call your patient to schedule the appointment with us.

INTERNAL USE ONLY

Appointment Date: _____ Time: _____ Contact Person: _____