

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

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|--|--|---|
| <input type="checkbox"/> <i>First Available Physician</i> | <input type="checkbox"/> Fernando Kamalei Cruz, MD
Shoulder and Elbow Reconstruction
Hand Trauma and Upper Extremity Trauma | <input type="checkbox"/> Armen Martirosian, MD
Orthopaedic Trauma Fracture Care |
| <input type="checkbox"/> Keiko Amano, MD
Shoulder Specialist | <input type="checkbox"/> Nathan Hoekzema, MD
Orthopaedic Hand, Elbow,
and Upper Extremity. Fracture Care | <input type="checkbox"/> Arbi Nazarian, MD
Hip and Knee Replacement and Revisions |
| <input type="checkbox"/> Michael Allen, DO
Orthopaedic Trauma Fracture Care | <input type="checkbox"/> Robert Kollmorgen, DO
Hip Preservation and Sports Medicine
Specialist | <input type="checkbox"/> Lucas Seiler, MD
Hand Surgery |
| <input type="checkbox"/> Mark Ayoub, MD
Orthopaedic Trauma Fracture Care | <input type="checkbox"/> Eric Lindvall, DO
Post Traumatic Reconstruction/Traumatology
Pediatric and Adult Fracture Care | <input type="checkbox"/> Johnny Wang, MD
Orthopaedic Trauma Fracture Care |
| <input type="checkbox"/> Kelsey Bonilla, MD
Orthopaedic Trauma Fracture Care | | |

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