

FAX REFERRAL FORM

Date: _____ Number of Pages: _____

- | | | |
|-------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> <i>First Available</i> | <input type="checkbox"/> Shreela Mishra, MD | <input type="checkbox"/> Diabetes Class |
| <input type="checkbox"/> Varsha Babu, MD | <input type="checkbox"/> Leonid Vydro, MD | |
| <input type="checkbox"/> Mandeep Gill, MD | <input type="checkbox"/> Aleyna Besmer, RDN
Registered Dietician Nutritionist | |

Patient Name: _____ DOB: _____

Patient Home Phone: _____ Patient Cell: _____

Diagnosis (required): _____

Referring Physician: _____

Phone: _____ Fax : _____

PCP (if different from referring): _____

Insurance: _____

REQUIRED PATIENT INFORMATION All information below is needed to schedule an appointment.

- Referral (Must include HMO referral for appointment to be scheduled.)
- Patient insurance card and demographics
- Last chart notes, H & P
- Last lab results/CT reports/Ultrasound reports (must have at least 1) (If Applicable)
- Medication list

Thank you very much for referring your patient to our office.

OFFICE USE ONLY:

Appointment Date at UDES: _____ Time: _____ with Dr.: _____

Unable to contact - **Referral Closed** _____