Community Neuroscience Institute • Fresno
7257 North Fresno Street, Fresno, California 93720
Office: (559) 22SPINE (227-7463) | (559) 22BRAIN (222-7246)
Fax: (559) 451-3690

COMMUNITY HEALTH PARTNERS

Referrals can be made by faxing this form to our office.

Date: _____

FAX REFERRAL REQUEST

Number of Pages: _____

(Please do not send more than 30 pages)

NEUROLOGICAL SURGERY

☐ **Ian T. Johnson, M.D.** ☐ **R. Loch Macdonald, M.D., Ph.D.** ☐ **Nathan Deis, M.D.**
☐ **Salem El-Zuway, M.D.** ☐ **Mark Krel, D.O.** ☐ **Kaiyun Yang, M.D.** ☐ **First Available**

ENDOVASCULAR/NEUROINTERVENTIONALIST

☐ **Sea Mi Park, M.D., Ph.D** ☐ **Hana Choe, M.D.** ☐ **Jordan Ziegler, M.D.**

NEUROLOGY

☐ **Abdullah H. Lakhani, M.D.**

NEURO-ONCOLOGY

☐ **Carlen A. Yuen, M.D.**

REQUIRED PATIENT INFORMATION

☐ Copy of Insurance Card (both sides) and Demographic Sheet

☐ Insurance Authorization (Ex: TRICARE, HMO, etc.)

☐ Worker's Compensation: Claim Number, Date of Injury, Adjuster/NCM Name and Contact Info)

☐ Chart Notes

Has the patient been evaluated by a Neurologists or Neurosurgeon previously? ☐ Yes ☐ No
If yes: Please send reports

Has the patient had an MRI/CT or Xray in the last 6 months? ☐ Yes ☐ No
If yes: Please send reports

Has the patient been seen by pain management? ☐ Yes ☐ No
If yes: Please send last visit note

Has the patient been seen by Physical Therapy? ☐ Yes ☐ No
If yes: Please send first and last note only

Has the patient been seen by an Ophthalmologist? ☐ Yes ☐ No
If yes: Please send reports

Referring Physician: _____ Phone: _____

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

Patient Name: _____ Date of Birth: _____

Patient Home Phone: _____ Patient Cell: _____

Consultation For (**Do not place ICD-10 codes***): _____

Insurance: _____

Office Contact Person: _____ Fax: _____

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

www.communityhealthpartners.org/community-neurosciences-institute-fresno