

POMONA CAMPUS
255 E. Bonita Avenue
Pomona, CA 91767



909/596-7733
Fax 909/593-0096
Specialty Clinic 909/450-0158

REFERRAL TO SPECIALTY CENTER PHYSICIANS

Patient Name _____ DOB _____

Address _____ Phone _____

City/State/Zip _____ Primary language _____

DIAGNOSIS/REASON FOR REFERRAL (Include problem and specify site; please be as detailed as possible) _____

PLEASE PROVIDE THE FOLLOWING:

- | | | |
|---|---|--|
| <input type="checkbox"/> Consultation and follow-up treatment | <input type="checkbox"/> Second opinion | <input type="checkbox"/> Call to collaborate |
| <input type="checkbox"/> Evaluation and follow-up treatment | <input type="checkbox"/> Recommend protocol | |

Specialty Programs and Procedures

POMONA CAMPUS

REFERRED FOR:

- | | |
|---|---|
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Nephrology |
| <input type="checkbox"/> Complete | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Limited | <input type="checkbox"/> Neuro-Optometry |
| <input type="checkbox"/> Exercise Treadmill Test (ETT) | <input type="checkbox"/> Parkinson's / Movement Disorders |
| <input type="checkbox"/> Stress Echo | <input type="checkbox"/> Physical Medicine / Rehabilitation |
| <input type="checkbox"/> ECG | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Ehlers-Danlos Syndrome (EDS) | <input type="checkbox"/> Pulmonology |
| <input type="checkbox"/> EMG | <input type="checkbox"/> Senior Evaluation |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Spasticity |
| <input type="checkbox"/> Hyperbaric Medicine | <input type="checkbox"/> Spine / Back Pain |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Wound Care (other) |
| <input type="checkbox"/> Limb Preservation / Wound Care | <input type="checkbox"/> Other _____ |
| | _____ |

REFERRED TO _____
(physician)

FOR _____

Physician: In order to provide a comprehensive consultation, please fax pertinent medical records.

Physician Name _____

Signature _____

Comments _____

Date _____ UPIN _____

Phone _____ Fax: _____

Address _____

City/State/Zip _____

POMONA

255 E. Bonita Avenue, Pomona, CA 91767 • 909/596-7733

Fax 909/593-0096 • Specialty Clinic 909/450-0158

