



DATE: _____
OF PAGES: _____

OB/GYN REFERRAL FORM
Please indicate the urgency of the visit:

- Urgent, STAT
- Within _____
- Next Available

722 Medical Center Drive East
Suite 101, Clovis, CA 93611
(559) 297-9500
www.wscclouis.com

PATIENT DEMOGRAPHICS

Please print and indicate the patient's name as it appears on the insurance card(s)

Patient Name _____

Date of Birth _____ Phone _____

Address _____ City _____ Zip _____

Type of Insurance *(Please include all)* _____

Sante Insurance please send Sante referral. Tricare Insurance please send authorization.

- Provider Required
- Dan D. Dorough, M.D.
 - Lorenzo Lopez, M.D.
 - David W. Dorough, M.D.
 - Renee Halstead, C.N.M., N.P.

Diagnosis _____

Referring Physician _____ Referral Contact _____

PCP (If different) _____

Phone _____ Fax _____

Please include the following documentation (If applicable):

- Demographics Sheet and copies of the insurance card(s) (front and back)
- Physician progress notes and labs
- Radiology reports including pathology, ultrasound, mammogram, & x-ray

Appointment Date & Time: _____

Scheduling Contact Information
Fax Correspondance to 559-297-9572

Pt. notified: By Phone By Mail