SIMONIAN Sports Medicine CLINIC

A MEMBER OF SANTÉ FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION

REFERRAL FORM

Peter T. Simonian, M.D.

FAX (559) 439-7632

Please FAX completed Referral Form and Authorization

REFERRING PHYSICIAN INFORMATION

Referring Physician	Primary Care Physician
Referring Physician's Phone	Primary Care Physician's Phone
Contact Person	

PATIENT INFORMATION

Last Name	First Name	Initial

Street Address	City, State, Zip

Home Phone	Message or Cell Phone	Patient's Gender	Date of Birth
- - - - - - - - - -	- - - - - - - - - -	◯ Male ◯ Female	

Social Security Number	Work Phone	Employer
- - - - - - - - -	- - - - - - - - - -	

INSURANCE INFORMATION

Primary Insurance Carrier	Policy ID #
Secondary Insurance Carrier	Policy ID #
WORKERS COMP CARRIER'S NAME	WORKERS COMP ADJUSTER'S NAME
WORKERS COMP BILLING ADDRESS	

WORKERS COMP PATIENT'S PRIMARY TREATING MD **	WORKERS COMP CLM NUMBER	WORKERS COMP DATE OF INJURY
ADJUSTOR'S NAME	ADJUSTOR'S TELEPHONE	ADJUSTOR'S FAX
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** DR. SIMONIAN DOES NOT ACCEPT WORK COMP PATIENTS AS PTP, ONLY AS SECONDARY TREATING PHYSICIAN **

(Please fax copy of Doctor's First Report of Injury as well as current office visit reports, MRI results, etc.)

MEDICAL INFORMATION

Diagnosis

	Date of Study/Procedure	Facility Where Performed
CT		
MRI		
Xray		

	Date of Surgery	Type of Surgery
Surgery		
Surgery		

APPOINTMENT

Date of SSMC Appointment

Time of Appointment

SSMC Contact Person

Notes

Please fax copy of latest CT, MRI, Radiology and/or Operative Reports

When time between scheduling and appointment permits a Patient Information Packet will be mailed to the patient.