Physician Referral Form

Dan Dorough, M.D. | David Dorough, M.D. | Lorenzo Lopez, M.D.

OBGYN Referral Form: *Please indicate the urgency of the visit.*

____ URGENT, STAT

____ Next Available

____ Other: _____

PATIENT DEMOGRAPHICS

Please indicate the patient name as it appears on the insurance card(s).

Patient Name: Date of Birth:

Address: Phone:

Type of Insurance: (*please include all*)

For Santé Insurance, include the Santé referral. For Tricare Insurance, please include the authorization.

Provider Required

____ Dan M. Dorough, M.D. **____ David W. Dorough, M.D.** **____ Lorenzo Lopez, M.D.**

Diagnosis: Referring Physician:

Referral Contact: PCP:

Phone: Fax:

Please include the following documentation (If applicable):

Demographics sheet, physician progress notes, labs, radiology reports (including pathology), ultrasound, mammogram, X-rays.

Appointment Date & Time:

Scheduling Contact Information

Fax Correspondence to: (559) 297-9572

Patient notified by: ____ Phone ____Mail ____ Other

Today's Date: