Please fax the completed Patient Referral Form to 760-340-9152 with your patient's complete medical history and records including:

- Current Medications
- Surgeries/Procedures
- Diagnostic Test Reports, including actual films or tracings

PATIENT REFERRAL FORM

Referring Physician: ______________________ Email ______________________

Phone #: ______________________ Fax #: ______________________

Address: ____

____

____

Name of Patient Referred: ____

Date of Birth: ______________________ Social Security # ______________________

Phone # ____

Address: ____

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Insurance Information

PRIMARY COVERAGE				**SECONDARY COVERAGE**			
Insured's Name				Insured's Name			
Insurance Company				Insurance Company			
Claim Address				Claim Address			
Group #		Policy #		Group #		Policy #	

Please Indicate Physician Referred to:

____ Brom D. Beckerman, M.D.
____ Leon A. Feldman, M.D.
____ Andrew D. Frutkin, M.D.
____ Barry T. Hackshaw, M.D.
____ Damon E. Kelsay, M.D.
____ Puneet K. Khanna, M.D.
____ Khoi M. Le, M.D.
____ Thomas F. Murphy, M.D.
____ Lester D. Padilla, M.D.
____ Philip J. Patel, M.D.
____ Andrew M. Rubin, M.D.
____ Charlie W. Shaeffer, M.D.
____ Philip J. Shaver, M.D.
____ Eric M. Sontz, M.D.
____ No Preference/First Available

Reason for Referral: ____

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39000 Bob Hope Drive, Hal B. Wallis Building Rancho Mirage, CA 92270,
760-346-0642, Fax 760-340-9152