women's specialty center
OBSTETRICS & GYNECOLOGY
A Professional Association
at Clovis Community Medical Center

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

DATE:_____
OF PAGES:_____

OB/GYN REFERRAL FORM

Please indicate the urgency of the visit:

☐ Urgent, STAT
☐ Within _____
☐ Next Available

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