

HONGSHIK HAN, M.D., INC.
Plastic, Reconstructive, Hand & Microsurgery
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PATIENT REFERRAL FORM

Patient Name _____ Date _____

Patient Contact #s _____ DOB: _____

Primary Ins _____ 2nd Ins _____

Workers' Comp? Yes No (requires referral with auth as secondary treater)

DX _____

Request for Appt _____ ASAP _____ Next available

Referring MD _____ Contact _____

MD Phone _____ MD Fax _____

Please include: Patient demographics, copy of insurance card(s), diagnostic / imaging results, office notes. Patients need to hand carry their imaging CDs so please be sure they are aware of this.

****Note: the ONLY HMO plans we accept are thru Sante****

Patient Appointment Date / Time _____

Thank you for the referral!
Questions? Contact Laurie, New Patient Registration