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FAX REFERRAL FORM

TO: Vivian Y. Kim, MD, MPH, FACS

FAX TO: (209) 546-6064 DATE: _____ TIME: _____No. Pages _____

Your patient will be contacted by an Advanced Retina Care staff member to schedule an appointment with Dr. Vivian Y. Kim. All urgent appointments must be scheduled by calling the office at 559-702-1212.

FROM:

Referring Doctor Name: _____

Office Address: _____

Phone: _____ Fax: _____

Reason for Consultation: _____

Comments: _____

PATIENT INFORMATION: (please attach any relevant notes)

Name: _____DOB: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell or Work Phone: _____

Insurance: _____

SCHEDULED FOR EXAMINATION with Dr. Kim:

Date: _____ Time: _____

Comments: _____

THANK YOU FOR YOUR REFERRAL