Christopher G. Katcherian, MD

SURGERY OF THE HAND & WRIST

Referral Request

Thank you for choosing our office:
Christopher Katcherian, Surgery of the Hand & Wrist

We look forward to partnering with you in your patient's care.

Phone: 949-536-5110
FAX THIS FORM TO: 888-521-1214

☐ ROUTINE ☐ URGENT

REFERRING PROVIDER INFORMATION:

Referred by (MD): _____
Medical Group: _____
Phone: _____ Fax: _____
Address: _____ City:_____ Zip:_____
This form is completed by: _____

PATIENT INFORMATION (*Please provide copy of patient demographics/face sheet*):

Last Name: _____ First Name: _____ MI: _____
DOB: _____ Phone: _____ Gender: ☐ Male ☐ Female
Patient's Address: _____
City/State/Zip: _____
Needs interpreter? ☐ Yes ☐ No Language: _____

REASON FOR REFERRAL:

Diagnosis/ICD: _____
Service Requested (initial, follow up, surgery, 2nd opinion):_____

Reason for Referral:

_____
_____
_____
_____
_____
_____

DOCUMENTATION *(Please fax with this form)*:

- Recent/relevant typed clinical notes/test results, i.e. history & physical, MRI/Ct/X-rays results
- Proof of insurance
- Authorization information (*if required*)