inspire HEALTH MEDICAL GROUP

Orthopaedics
604 N Magnolia, Suite 100,
Clovis, CA 93611
559.320.0531
559.432.3025 Fax Referrals
InspireHealth.org

FAX REFERRAL REQUEST • Referrals can be made by faxing this form or calling the office

- ☐ *First Available Physician*
- ☐ **Keiko Amano, MD** – Shoulder Specialist
- ☐ **Michael Allen, DO** – Orthopaedic Trauma Fracture Care
- ☐ **Raj M. Amin, MD** – Hip and Knee Replacement and Revisions, and Orthopaedic Shoulder Care
- ☐ **Mark Ayoub, MD** – Orthopaedic Trauma Fracture Care
- ☐ **Kelsey Bonilla, MD** – Orthopaedic Trauma Fracture Care
- ☐ **Fernando Kamalei Cruz, MD** – Orthopaedic Hand, Elbow, and Upper Extremity. Fracture Care
- ☐ **Nathan Hoekzema, MD** – Orthopaedic Hand, Elbow, and Upper Extremity. Fracture Care
- ☐ **Robert Kollmorgen, DO** – Hip Preservation and Sports Medicine Specialist
- ☐ **Eric Lindvall, DO** – Post Traumatic Reconstruction/Traumatology Pediatric and Adult Fracture Care
- ☐ **Armen Martirosian, MD** – Orthopaedic Trauma Fracture Care
- ☐ **Arbi Nazarian, MD** – Hip and Knee Replacement and Revisions
- ☐ **Geoffrey Rohlfing, DO** – Hip and Knee Replacement and Revisions
- ☐ **Lucas Seiler, MD** – Hand Surgery
- ☐ **Johnny Wang, MD** – Orthopaedic Trauma Fracture Care
- ☐ **Spencer Woolwine, MD** – Orthopaedic Oncology, Arthroplasty, and Trauma

Date: ____________________

Referring Physician: ____________________ Phone: ____________________

PCP (if different from referring): ____________________ Phone: ____________________

Patient Name: ____________________ DOB: ____________________

Consultation For: ____________________

Diagnosis: ____________________

REQUIRED PATIENT INFORMATION **NOTE: All information is needed to schedule an appointment.*

- ☐ Copy of Referral
- ☐ Copy of Insurance Card/Demo Sheet
- ☐ Last Chart Notes
- ☐ Copy of Lab Results
- ☐ X-Ray/Ultrasound Reports

☐ Films requested from: ____________________

For delivery to:

604 N Magnolia, Suite 100
Clovis, CA 93611

Special Instructions: ____________________

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Contact person: ____________________ Title: ____________________

Phone: ____________________ Fax: ____________________ Comments: ____________________

INTERNAL USE ONLY

Appointment Date: ____________ Time: ____________ Contact Person: ____________________

☐ Office Notified ☐ Patient Notified Initials ____________

Workers Compensation Referral Please Fax To: 559.432.3025