



## Referral Information

Please fill in information and fax to (210) 946-1010.

### Physician

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Patient

Patient Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

### Diagnosis

Patient Diagnosis/Concern \_\_\_\_\_

Short History \_\_\_\_\_

### Tests

Pathology Test \_\_\_\_\_ Date/Location of Test \_\_\_\_\_

Result \_\_\_\_\_

Please include copies of pathology reports and other test reports from past 90 days. \_\_\_\_\_

### Comments for Dr. Kahlenberg and Staff

\_\_\_\_\_  
\_\_\_\_\_

### Clinic Manager:

**Robert Edwards, RN, (210) 946-1400**

**Urgent Referrals – call (210) 748-5096**