California Sinus Centers

Thank you for referring your patient to California Sinus Centers!

Please complete and fax to:

Dr. Karen Fong (925) 906–9780 / Dr. Winston Vaughan: (650) 366-4930

Referring Provider: _____

Phone number: _____ **Fax number:** _____

Patient name: _____

Phone number: _____ **Date of Birth:** _____

Does this patient have health insurance? ***Please include a copy of the front/back of the insurance card.***

Please evaluate and treat this patient for: _____

Schedule this patient with:

☐ **DR. KAREN FONG –** ***please select a location.***

☐ WALNUT CREEK ☐ PLEASANTON

☐ **DR. WINSTON VAUGHAN –** ***please select a location.***

☐ ATHERTON ☐ WALNUT CREEK ☐ SONOMA ☐ FRESNO/CLOVIS

Appointment date (*PLEASE SELECT ONE*):

☐ URGENT ADD ON (IMMEDIATELY) ☐ THIS WEEK ☐ NON-URGENT (2-4 WEEKS)

BY THIS DATE: _____

I would like to receive consult notes via (*PLEASE SELECT ONE*):

◯ AUTOMATIC FAX ◯ MAIL (include address): _____

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