



REFERRAL FORM

Referral Line: (530) 258-2882
Lake Almanor Clinic
199 Reynolds Road Chester, CA 96020
Office Phone (530) 258-3648 Fax: (530) 258-2785

Referring physician: _____ Date: _____

Refer to: _____

Patient Name: _____ DOB: _____

Phone number: _____ Insurance: _____

Reason for referral/diagnosis: _____

Attach documents

Clinic note: ___ Radiographic reports **WITH** Images: ___ Lab reports: ___ Medication lists: ___

Other: _____

Internal Use Only Below This Line

Note date when attempt was made to make referral: _____

Referral completed by: _____ Date: _____

Date & time of appt: _____

Special instructions: _____

Patient notified on: _____ *Initial* _____