Physician Foundation at California Pacific Medical Center

A Sutter Health Affiliate

Community Based, Not For Profit

Pediatric Specialty Services

Referral Form

3700 California St. B555
San Francisco, CA 94118
Toll Free: 866..663.KIDS
Tel: 415. 600.0750
Fax: 415. 600.0755

Cardiology
Nikola Tede, MD, FAAP
Andrea Leavy-Sperounis, CPNP
Alice Pilram, RN, MS, PNP
Sonographer
Wilhelmina Organist, ARDMS, RDCS

Endocrinology
Suruchi Bhatia, MD
Enyo Dzata, NP
Kim Clash, NP

Gastroenterology, Hepatology and Nutrition
Jose Antonio Quiros, MD, FAAP
Phuong Christine Nguyen, MD
Sarah Boushey-George, CNP
Elizabeth Ruben, CNP
Elaine McCann, RN
Lonnie Wong, RD, CNSD

Genetics
Mahin Golabi, MD
Sharon Chan, Genetic Counselor

Neurology
Farhad Sahebkar, MD
Sheila Jenkins, MD
Sylvia Balding, NP
Onica Kuch, NP

Hematology and Oncology
Sandra Luna-Fineman, MD
Louise Lo, MD
Joan Battaini, RN

Biofeedback
Ruby Ng, MPT, BCIAC

Social Worker
Cathy Portje-Richardson, MSW

Medical Records
Tel: 415-600.0754
Fax: 415-600.0744

Scheduling Department
Tel: 415.600.0770
Fax: 415.600.0775

Patient Information *(Please complete)*

Last Name: ____________________________ First Name: _________________________

Date of Birth: ___________________ SSN (If available) ____________________________

Contact Information *(Please complete)*

Name: ____

Relationship to patient: ____

Daytime phone: ________________________ Alternate phone: _____________________

Medical Information *(Please complete)*

Referring Physician: ____

Address: _________________________ City: _______________________ Zip:_________

Phone: ___________________ Fax: ______________________

*Physician or Specialty you are requesting: _____________________________________

Appointment Status: Urgent ☐ (If the appointment is urgent, please call) Routine ☐

Patient History *(Please attach the following)*

- Recent Progress Notes
- Lab, X-ray or other tests performed
- Hospitalization Records
- Growth Chart
- Recent or present medications
- Other significant notes

Diagnosis: ____________________________

Insurance Information *(Please attach your face sheet or complete)*

Name of Insurance: ____

Address: _______________________ City: _________________ State: ___ Zip:_________

Subscriber Number: __________________________ Group Number: _________________

Policy Holder: _______________________________ Date of Birth: __________________

Authorization Number: ____

OFFICE USE ONLY

DATE SCHEDULED: ___________________________ REFERRING MD NOTIFIED BY: _______________ DATE: _____________