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IGNACIO ITURBE, M.D.
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Referral Information Request

DATE: ______________________________

TO: ____

Phone:_____________________________ **Fax:**_________________________

Your Patient:___________________________ **DOB:**______________________

Has an appointment to see Dr. ____

on ______________________________.

Please fax the following information to our office:

1. **Patient demographics**
2. **Copy of Patient's insurance card (front & back)**
3. **Authorization**
4. **Progress notes regarding referral.**
5. **Reports pertaining to this referral which may include,**
   Lab
   Radiology
   Pathology
   Surgical

Thank you,

Patient Coordinator

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