

# HIMMAT S. GILL, M.D., INC.

*Board Certified in Rheumatology*

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## Patient Referral

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work: \_\_\_\_\_

Type of Insurance: \_\_\_\_\_

### Referring Physician Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

NPI#: \_\_\_\_\_

### Reason for referral/diag:

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- Copies of any recent labs, radiology or progress notes.
- Copies of current insurance cards & patient demographics.