THE HAND CENTER OF SAN ANTONIO
REFERRING PHYSICIAN FAX COVERSHEET

FAX TO: 210-558-4664
PHONE: 210-478-5224

PRIORITY REFERRAL

FAX ATTN: **Referring Physician Intake**	**FROM:**
DATE:	**REFERRING MD:**
TOTAL PGS INCL COVER:	**PHONE #:**
	FAX #:

PATIENT REFERRED TO: **NEXT AVAILABLE PHYSICIAN**

DR. GREEN	**DR. PEDERSON**	**DR. BAGG**
DR. PERSON	**DR. SRINIVASAN**	**DR. SAUCEDO**

Please attach:

- DEMOGRAPHICS SHEET
- INSURANCE CARD(S)
- REFERRAL/AUTHORIZATION (IF REQUIRED)
- RELATED MEDICAL RECORDS

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