



CALIFORNIA SINUS CENTERS

Thank you for referring your patient to California Sinus Centers!

Please complete and fax to:

Dr. Karen Fong (925) 906-9780 / Dr. Winston Vaughan: (650) 366-4930

Referring Provider: _____

Phone number: _____ Fax number: _____

Patient name: _____

Phone number: _____ Date of Birth: _____

Does this patient have health insurance? Please include a copy of the front/back of the insurance card.

Please evaluate and treat this patient for: _____

Schedule this patient with:

DR. KAREN FONG – please select a location.

WALNUT CREEK PLEASANTON

DR. WINSTON VAUGHAN – please select a location.

ATHERTON WALNUT CREEK SONOMA FRESNO/CLOVIS

Appointment date (PLEASE SELECT ONE):

URGENT ADD ON (IMMEDIATELY) THIS WEEK NON-URGENT (2-4 WEEKS)

BY THIS DATE: _____

I would like to receive consult notes via (PLEASE SELECT ONE):

AUTOMATIC FAX MAIL (include address): _____

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