This referral is valid for the initial visit to a specialist. Additional specialist visits need to be requested on the PCP and Specialist Request for Services form. Or you may submit your authorization via MCSOnline.

DMG Delano Medical Group

Dignity Health Medical Network

Direct Referral

PCP	PCP PHONE	PCP FAX	HEALTH PLAN

Patient Identification

PATIENT'S LAST NAME		FIRST NAME	
HOME PHONE	WORK PHONE		DATE OF BIRTH
SUBSCRIBER'S LAST NAME	FIRST NAME		SUBSCRIBER ID#

Services Requested

☐ **ALLERGY**

Kern Allergy Medical Clinic
PHONE: 721.8832
FAX: 721.8319

☐ **CARDIOLOGY**

Advanced Cardiology Medical Associates
PHONE: 633.2541
FAX: 633.9042

Comprehensive Cardiovascular Medical Group
PHONE: 725.7818
FAX: 725.3484

☐ **OTOLARYN-GOLOGY (ENT)**

Wilbur Suesberry, MD
PHONE: 721.1422
FAX: 721.2738

☐ **GASTRO-ENTEROLOGY**

☐ **SCREENING COLONOSCOPY**

Institute of Advanced Gastro. Medical Associates
PHONE: 721.1200
FAX: 721.1204

Kern Gastro. Medical Group
PHONE: 324.1203
FAX: 324.3195

☐ **NEPHROLOGY**

Kern Nephrology Medical Group
PHONE: 324.4721
FAX: 324.2328

☐ **NEUROLOGY**

Boota Chahil, MD
PHONE: 721.9226
FAX: 206.4081

☐ **OB/GYN**

Delano Women's Medical Clinic
PHONE: 721.0737
FAX: 721.0738

Rahul Sharma, MD
PHONE: 725.2512
FAX: 725.2586

Gloria Nelson Center for Women and Children
PHONE: 725.1010
FAX: 725.1117

☐ **OPHTHAL-MOLOGY**

Triangle Eye Institute
PHONE: 721.2020
FAX: 721.2401

NOTE: Do not use this form for diagnosis for obesity or varicose veins. Use the PCP and Specialist Request for Services form for these diagnoses.

☐ **PULMONOLOGY**

Pramil Vaghasia, MD
PHONE: 661.725.6910
FAX: 661.725.6912

☐ **UROLOGY**

Anthony Horan, MD
PHONE: 725.4847
FAX: 725.8051

☐ **ORTHOPEDIC SURGERY**

Pramod Srivastava, MD
PHONE: 725.0713
FAX: 721.2629

☐ **VASCULAR SURGERY**

Sheikh Latif, DO
PHONE: 877.360.8346
FAX: 877.360.8346

Karim Zahriya, MD
PHONE: 725.4847
FAX: 725.8051

☐ **GENERAL SURGERY**

☐ **SCREENING COLONOSCOPY**

Ayman Al Harakeh, MD
PHONE: 375.5871
FAX: 375.5877

Karim Zahriya, MD
PHONE: 725.4847
FAX: 725.8051

Reason for Referral

DIAGNOSIS	MEDICAL RECORDS ☐ Faxed on (date) _____ ☐ Being sent with patient
SYMPTOMS	WORKUP PERFORMED

Instructions for the Patient

Contact the doctor's office for an appointment date and time. Take this form with you to the appointment as it has important information.

APPOINTMENT DATE	DAY OF WEEK	TIME
TO SEE DR.	PHONE	ADDRESS

PHYSICIAN'S SIGNATURE	DATE

THIS FORM IS AVAILABLE AT: MCSOnline/Provider Resources/Forms/Authorization Forms/Direct Referral