



JOHN R. OISHEI
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Rabheh Abdul Aziz, MD, MS
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NEW PATIENT REFERRAL FORM

Patient Name: _____ DOB: ____/____/____

Address: _____ City: _____ State: _____

Referring Provider: _____

PMD (if different than above): _____

Phone: _____ Fax: _____

Insurance: _____ Member #: _____ Group: _____

Reason for Referral (History of Condition/Diagnosis, Pertinent Labs, X-Rays or Studies, Meds):

*Please attach all pertinent clinic notes, laboratory testing and imaging results.

*Please see the patient:

- ASAP
- Next available appointment

Please complete this form and fax it back to our office at 716.323.6671. Be sure to include all recent lab work and other testing. Please allow five business days for a new appointment to be scheduled for your patient.

If you need to reach our office, please call 716.323.6240. Thank you for your referral.