

Fax Referral Sheet (623) 266-1746

This form is intended for use by medical offices and their staff who wish to refer a patient to Sunshine Health Care Center. Please complete the form and provide the requested information. After completion, the form can be faxed to the number above. Our staff will promptly process your request and contact you and/or the patient within 48 hours. If you have questions about this process, please call our office at **(623) 266-1722**.

Referring Physician Information Last name: _____ First name: Primary office contact: Phone: _____ Fax: _____ Email: _____ **Patient information** Last name: First name: Date of Birth: ____/___ Gender: ☐ Male ☐ Female Day time phone: Alternate phone: Insurance Provider: ____ Insurance ID Number:

Appointment Information Reason for Referral (Diagnosis): Patient Medical History:			
		(Attach pertinent reports including: recent labs, imaging, and progress notes)	
		Requested physician:	
☐ Dr. Tiffany Mitchell, NMD ☐	Dr. Ashley Chung, NMD		
☐ Dr. Lena Bojaj Fernandez, NMD			
Other comments:			
Referring Physician Office Checklist:			
☐ Medical Records ☐ Labs and Imag	ging (if applicable)		
☐ History and Physical Exams (if applicable	e)		
☐ Other			
 Bio-identical Hormone Replacement 			
Natural Pediatric Wellness and Sick Care	Acupuncture		
Adjunctive Care for Oncology Patients	Botanical Medicine		
Homeopathy	 Hydrotherapy		
Nutrition and Lifestyle Counseling	Preventive Medicine		

5620 West Thunderbird Road, E-1
Glendale, AZ 85306

Nutrient IV therapy

PRP Therapy

Phone: **(623) 266-1722** Fax: **(623) 266-1746**

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