

**FAST TRACK FAX  
210-595-1175**
**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Insurance: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ NPI: \_\_\_\_\_

Authorization Number: \_\_\_\_\_ Office Phone: \_\_\_\_\_

**PHYSICIAN AND LOCATION**

**MEDICAL CENTER**

<input type="checkbox"/> J. Mark Cheek, M.D.	<input type="checkbox"/> Jon Pelzl, M.D.
<input type="checkbox"/> Brad Gurwitz, M.D.	<input type="checkbox"/> Thomas Shary, M.D.
<input type="checkbox"/> Grace Hsiung, M.D.	<input type="checkbox"/> Sarah Weakley, M.D.
<input type="checkbox"/> Travis Holloway, M.D.	<input type="checkbox"/> Russell Woodard, M.D.

**WESTOVER HILLS**


Daniel Vargas, M.D.       Jon Pelzl, M.D.

**FIRST AVAILABLE APPOINTMENT**

Medical Center       Westover Hills

**EVALUATE AND TREAT**

<input type="checkbox"/> Hernia	<input type="checkbox"/> Parathyroid
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Medi-Port Placement
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> GERD/Reflux
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Abscess
<input type="checkbox"/> Other: _____	
_____	
_____	



Abnormal Mammogram

Benign / Malignant Breast Disease

Male Breast Issues

Breast Pain

Breast / Axilla Lump

Breast / Nipple Skin Changes

High Risk Patients

Family History of Breast Cancer

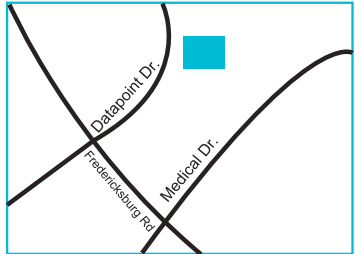
Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Please send Referral Form, Patient Demographics and Diagnostic Test Results*

<b>FAX</b> 210-595-1175	<b>ONLINE</b> LeadingReach.com
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