



AFFILIATED PHYSICIAN PRACTICE INC.

Stephen A. DeSantis, MD, FACS  
General Surgeon

Jonathan J. Mayer, MD, FACOG, FACS  
Obstetrics & Gynecology  
Pediatric & Adolescent Gynecology

Jennifer Ng, MD, FACOG  
Obstetrics & Gynecology

Bakht Roshan, MD  
Infectious Disease

**New Patient Referral**  
(559)675-8990 Fax (559)675-8994

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Street Address: \_\_\_\_\_ City/Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/Zip Code: \_\_\_\_\_

Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Referral Information**

Refer to:

General Surgery  Stephen A. DeSantis, MD, FACS

Infectious Disease  Bakht Roshan, MD

Obstetrics & Gynecology  Jonathan J. Mayer, MD, FACOG, FACS  Jennifer Ng, MD, FACOG

Pediatric & Adolescent Gynecology  Jonathan J. Mayer, MD, FACOG, FACS

Reason for Referral: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Office Number: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Please provide all applicable referral information including: progress notes, medical imaging and lab reports. Include a copy of the patient's insurance card including front and back. We will schedule the appointment with the patient directly. Please note if you would also like to be notified of the appointment date and time.

Yes, please confirm my patient's appointment date

Referring provider's office notified: \_\_\_\_\_  
By Date Method