

Cirugía Sin Fronteras | CSF Surgery
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REFERRAL FORM

***ONLY FOR POTENTIAL SURGICAL PATIENTS WHO ARE MEDICALLY UNINSURED/UNDERINSURED**

***NOT FOR GENERAL OR INTERNAL MEDICINE**

Please send via e-mail to referrals@csfsurgery.com or via fax to 661.327.7255

Referred to:

- General Surgery
- Cardiology

- Gynecology/Obstetrics
- Ear, Nose & Throat
- Orthopedic Surgery

- Podiatry
- Urology
- Ophthalmology

- Plastic and Reconstructive Surgery

Date: _____ Clinic or Primary Care Provider: _____

Referrals/Contact (name): _____ Email: _____

Phone Number: _____ ext: _____ Fax: _____

PATIENTS INFORMATION

Name: _____ DOB: _____

Address: _____ Phone: _____

DX: _____

Comments:

Please send a copy of the patient's diagnosis, recent imaging studies, and lab work.
For any questions, please contact us. Thank You!