

Physician Referral Request
Michael Kazim, M.D., P.C.

Dear Dr. _____

Patient Name: _____

Address: _____

Home Number: _ (_____) _____

Work Number: __ (_____) _____

Insurance: _____

Needs to be seen: *Immediately* *2 days* *1 week* *other*

For: *Evaluation* *Treatment* *2nd opinion* *other*

Comments:

Please evaluate and treat for _____

Please communicate via: *Fax* *Mail* *Phone*

635 West 165 th Street Suite 207
New York, New York 10032
Phone: (212) 305-5477
Fax: (212) 923-0075