



Date: _____

Today we referred: _____ Adult Child

Patient Phone Number: () _____

For consultation regarding:

An appointment has been scheduled on:

Date: _____ Time: _____

Patient will call for an appointment.

Dr. Shemirani's office should call patient to schedule a visit.

Radiographs: Available Sent by mail/e-mail Given to patient

Referring Doctor: _____ Date: _____

1289 E. Hillsdale Blvd. | Ste. 1
Foster City, CA 94404
650.349.6835

3705 Beacon Ave. | Ste. 100
Fremont, CA 94538
510.793.9025