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Referral Form

Patient Name: ____

Patient DOB: ____

Patient Phone #: ____

Referring Doctor: ____

Referring Doctor's Fax: ____

Diagnosis: ____

Medical Insurance: ____

Referring to:

☐Dr. Jose Daniel Diaz M.D. ☐Dr. Diana Shechtman ☐Dr. Anne L. Kunkler M.D.

Please FAX referrals to (305) 760-4719 or EMAIL to Referrals@rcomiami.com

Please call for a direct response (305) 712-6711

Our Address:

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Miami, Fl 33133

(Please find us across the street from the Coral Gables Hospital)