



747 52nd Street, Oakland, CA 94609 • www.childrenshospitaloakland.org

Referral Card

Date _____

Dear Parent/Guardian,

Your child has been referred to the _____ service at
Children's Hospital & Research Center Oakland to see Dr. _____ (optional)
for evaluation of _____.

Please call 510-428-_____ to arrange this appointment. Thank you.

_____, MD

.5K 905



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