

NEW PATIENT REFERRAL FORM

Please fully complete this form in order for us to serve you and the patient efficiently. Once you have completed this form and obtained the necessary medical records, please fax or email using the above provided contact information. Appointment scheduling is determined by the severity of illness and is scheduled directly with the patient. Once we have secured an appointment with the patient you will receive notification of the date and time of the appointment. If we are unable to reach the patient by the third phone call; we will notify your office so that follow up can occur with the patient. We thank you for your referral and we appreciate the opportunity to serve you and the patient.

When to Refer?

Urgent Referrals- Call & Fax (Immediate-2 Days)

- Gross Hematuria
- Urinary Retention w/o Catheter
- Obstructing Stone
- Untreated UTI w/ Fever and Chills

Immediate Referrals (3-10 Days)

- Renal, Bladder, and Testicular Masses, Lesions, and Etc.
- Micro Hematuria (not chronic)
- Elevated PSA

Routine Referrals (1-3 Weeks)

- Kidney Stone (Asymptomatic)
- Chronic UTI
- Erectile Dysfunction
- Prolapse
- Incontinence
- Benign Prostatic Hyperplasia (BPH)

Patient Name: _____ DOB: _____

SSN: _____ Circle One: MALE FEMALE

Address: _____

Home: (____) ____-____ Cell: (____) ____-____ Work: (____) ____-____

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Insureds Name: _____ Insureds SSN: _____ Insureds DOB: _____

Claims Address: _____

Referring Physician: _____ Referring Group/Clinic: _____

Office Number: (____) ____-____ Office Fax Number: (____) ____-____

Referral Reason: _____

Comments: _____

Please include the following items: _____ BMP / CMP / CBC _____ Urine Studies _____ Med List
(Last 6 Months) (Last 12 Months)

_____ Physician Notes _____ Diagnostic Studies _____ Operative notes / Pathology Reports
(Last two OV) (Any Imaging Related to Care) (Any Related to Care)

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