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UROLOGY REFERRAL FORM

Patient's Name: _____

DOB: _____ Phone#: _____ Cell#: _____

Address: _____

Insurance Carrier: _____

Policy #: _____

Referral authorization # if required _____

Please include clinical documentation such as imaging, lab work, clinic notes, if available.

1. Is this an emergent urology referral? ☐ No ☐ Yes (If Yes, please explain)

_____

2. Please describe the patient's chief complaint and *include onset and frequency*:

_____

_____

_____

_____

To expedite appointment scheduling, please provide the following by fax: (256) 203-8684

- ☐ This completed form
- ☐ Most recent office note
- ☐ Medical Records related to chief complaint
- ☐ Lab & test results within the last year
- ☐ Prior Authorization, or if not applicable, a copy of insurance card

Referring Provider: _____

Provider Address/Location: _____

Phone #: _____ Fax #: _____

Provider Signature: _____ Date: _____

Appointment Date/Time: _____ Patient notified on: _____

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures

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