CULLMAN REGIONAL | Medical Group

*Urology Clinic*
*Matthew Young, MD • Niki Brooks, CRNP*
1948 AL Highway 157, POB 1, Suite 330
Cullman, AL 35058
**Phone: (256) 737-2177 FAX: (256) 203-8684**

# 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*

**Phone (256) 737-2177 Fax (256) 203-8684**