CULLMAN REGIONAL | Medical Group

Urology Clinic
Leor Arbel, MD • Rodney Sanders, MD
Matthew Young, MD
Nichole Brooks, CRNP • Melissa Young, PA
1948 AL Hwy 157, POB 1 Suite 450, 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