



Urology – New Patient Referral Form
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Please complete this form and fax it, along with all **pertinent medical records** (progress notes, imaging, PSA, labs, operative reports, pathology) along with a **copy of the patient's insurance card and demographics**.

Patients will not be scheduled until we receive this completed form and medical records.

Name: _____ Date of Birth: _____

Phone: _____

Address: _____

SS#: _____

Insurance: (Primary) _____ (Secondary) _____

Primary Language: _____

Interpreter needed Yes: _____ No: _____

Latex Allergy Yes: _____ No: _____

REFERRING PROVIDER: _____

Reason for referral (with ICD---10 codes):

Current Medications (including OTC):

Allergies:

Form completed by: _____ Phone: _____ Date: _____

RETURN FAX TO: (574) 534-5722

PHONE: (574) 533-8420

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