Goshen Physicians
UROLOGY

Urology – New Patient Referral Form

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

Office: 1808 Charlton Ct
Goshen, IN 46526