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NEW PATIENT REFERRAL FORM

Date: ______________________

Patients Name: ___________________________________ DOB:_____________________________

Patients Phone Number(s): ___________________________ or ________________________________

Referring Doctor: _____________________________________

Phone # ________________________________ Fax # ____________________________________

Please Mark the Reason you are Referring the Patient:

STAT	**URGENT**	**ROUTINE**
☐ Renal Mass	☐ Kidney Stones	☐ Urinary Tract Infections
☐ Testicular Mass	☐ Hematuria	☐ Stress/ Urge Incontinence
☐ Prostate Cancer	☐ Elevated PSA	☐ OAB / Frequency / Urgency
	☐ Testicular Pain	☐ Hydrocele / Epididymal Cyst / Varicocele
	☐ BPH / Prostate Problems	☐ L ow Testosterone
Other _____________	☐ Urinary Retention with Catheter	☐ Erectile Dysfunction
		☐ Vasectomy
		☐ Infertility

Please Send with Referral :

- **Copy of Insurance Cards (Front and Back)**
- **Patient Demographics**
- **Insurance Authorization**
- **All CT/ Ultrasounds/ Labs/ Chart notes relevant to the patient diagnosis**

PLEASE ALLOW 5-7 DAYS FOR REFERRAL PROCESSING