Pediatric Urology
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Referral to Pediatric Urology

Patient Name:_____DOB:_____Sex:_____

Address:_____

Parent/Guardian's Name:_____

Phone #: (H):_____(M):_____(W):_____

Primary Insurance Co:_____ Secondary Insurance Co:_____

Policy#_____ Policy#:_____

Phone#_____ Phone#:_____

Does this appointment require an insurance referral? Y / N Ref/auth#_____

Referring Provider:_____

Phone#:_____Fax:_____

Patient's PCP (If different than Referring Provider):_____

Reason for Referral:_____ICD-10 _____

If referral is urgent-- please state why & call office -_____

_____

Has the patient ever been seen by a specialist for this problem before? Y N

If yes-Who, where, and when-_____

Has any imaging or testing been done related to this problem? Y N

If yes-Please specify where and when the following were completed:

Imaging (Ultrasound,CT, MRI,etc.):_____

Labs:_____

Other:_____

Please forward all records with intake form
All imaging needs to be sent electronically or mailed at time of referral
Insurance Information -must be completed for an appointment to be scheduled