Providence
UROLOGY SPECIALISTS

REFERRAL REQUEST

Please allow 10 business days for Non-STAT appts to be scheduled

AFTER 10 DAYS, PLEASE CALL PATIENT FOR APPT. VERIFICATION

PATIENT INFORMATION:

Name:_____SSN:_____ DOB:_____

Address:_____City/State/Zip:_____

Phone#:_____ Work#:_____Cell#:_____

*Diagnosis:_____

***For erectile dysfunction dx – patient should have failed use of oral medications prior to referral to us.**
***For UTI dx – patient should have had three positive cultures prior to us.**

INSURANCE INFORMATION:

Primary:_____Authorization Required?_____

Secondary:_____Authorization Required?_____

REFERRING PHYSICIAN:

Name:_____Contact Person:_____

UPIN:_____NPI:_____

Address:_____City/State/Zip:_____

Phone#:_____Ext:_____Fax#:_____

Appointment Time Frame:

STAT ☐ Within 1 Week ☐ 1st Available Appt ☐

Please fax back this form along with the following information:

- Office notes pertaining to referral
- Labs and other pertinent reports – for elevated PSA, send all PSA values within past 2 years, serum testosterone levels, urine culture results
- Clear copies of insurance cards
- Insurance referral if necessary

Please fax this information to (803) 365-8629.

Appointment Date:_____

Appointment Time:_____

Physician:_____