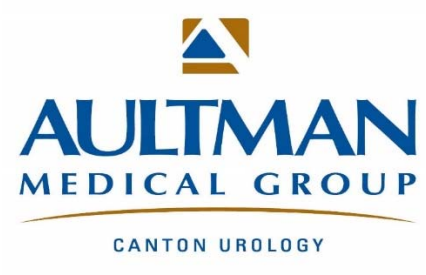

REFERRAL REQUEST

Please complete form and fax all records to 330-458-2010. It is imperative that we have a urological diagnosis completed. We will contact patient with appointment and return form back to you with date and time noted. If you have questions, please contact scheduling at 330-458-2000

Patient Name: _____ DOB: _____

Home Phone: _____ Cell: _____

Diagnosis for urological visit _____

Referring physician: _____ Contact Person: _____

Office Phone: _____ Fax: _____

Has patient been seen by a previous urologist: ☐YES ☐NO If so, name: _____

Does referral require prior authorization? ☐YES ☐NO Auth # _____

PLEASE FAX BACK ALL PERTINENT MEDICAL INFORMATION WITH REFERRAL REQUEST

(Patient demographics, current care plans, patient history, lab results, CT, MRI, Ultrasound of abdomen, pelvis)

_____

Appointment confirmation

Date: _____ Time: _____

Physician: _____

2600 West Tuscarawas #400 Canton, OH 44708 * Phone: 330-458-2000 * Fax: 330-458-2010