



PATIENT REFERRAL/APPOINTMENT FORM

PHYSICIAN REQUESTED/PREFERRED:

- BOYD CHENG COX RUTH ANN MAZO STEPHEN MICHIGAN
ANDREW MICHIGAN (NEW) SHOOK WALLACE FIRST AVAILABLE

PREFERRED LOCATION: SAVANNAH STATESBORO

- CHECK ONE: URGENT REFERRAL (1-2 days), FAX THIS FORM then call our Urgent Referral Hotline at 912/790-4056
ASAP Appointments (3-7 days)
Routine Referral - first available appointment
Referring Physician has already spoken with one of our physicians regarding this patient

WAS PATIENT SEEN IN THE E.R.? YES NO If Yes, what hospital?

PATIENT'S LAST NAME FIRST MIDDLE

DOB: / / MALE FEMALE SOCIAL SECURITY

ADDRESS CITY STATE ZIP

DAYTIME PHONE WORK PHONE CELL

PATIENT'S EMAIL ADDRESS

PRIMARY INSURANCE INFORMATION

INSURED'S NAME RELATION TO PATIENT

COMPANY NAME POLICY #

GROUP # REFERRAL NEEDED? YES NO REF #

CHIEF COMPLAINT

REFERRING MD NAME NPI# PHONE

NAME OF CALLER PHONE FAX

Please be sure to send us the following prior to the patient's appointment:

- Copy of insurance card Office notes related to patient's condition
Copy of Referral (if necessary) Labs/x-rays/diagnostic test reports

FOR UROLOGICAL ASSOCIATES OFFICE TO COMPLETE:

PATIENT HAS APPOINTMENT WITH DR. ON TIME OAM OPM

Appointment made by on this date

Thank you for your referral. Should you have any questions, call us at our MAIN PHONE 912/790-4000

FAX COMPLETED FORM TO 912/352-9031