UROLOGICAL Associates of Savannah, P.C.

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 ▢ RICHMOND HILL ▢ 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 ➢ Copy of Referral (if necessary	➢ Office notes related to patient's condition ➢ Labs/x-rays/diagnostic test reports

FOR UROLOGICAL ASSOCIATES OFFICE TO COMPLETE:

PATIENT HAS APPOINTMENT WITH DR. _____ ON _____ TIME _____▢AM ▢PM

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