



The Urology Division of Integrated Medical Services (IMS)

### FAX REFERRAL REQUEST: (623) 512-4391

This form is intended for use by medical offices and their staff who wish to refer a patient to Arizona Urology. Please complete the form and provide the requested information. After completion the form can be faxed to the number above. Our staff will promptly facilitate your request and contact you as well as the patient within one business day to confirm your request has been fulfilled. Should you have questions about this process, please call our Direct Referral Line at (623) 512-4273.

#### Referring Physician Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Primary Office Contact: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Confirm Appointment with Referring Doctor's Office Via  Phone  Fax  Email (Please check)

#### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
Day Time Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
Insurance Provider: \_\_\_\_\_ Insurance ID Number: \_\_\_\_\_

#### Appointment Information

Reason for Referral (Diagnosis): \_\_\_\_\_  
Patient Medical History: \_\_\_\_\_  
*(Attach pertinent reports including: PSAs, urine cultures, BMP, CBC, abdominal scans, progress notes)*  
Location Requested *(See Office Below)*: \_\_\_\_\_  
Other Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Referring Physician Checklist:

- Insurance Referral (Mandatory)
- Medical Records
  - Labs and X rays (If Applicable)
  - History and Physical (If Applicable)
  - Urine Tests (If Applicable)
- Other \_\_\_\_\_

**PLEASE NOTE:** In order for us to see provide best patient care and see the referred patient we will need a referral from the primary care physicians (PCP) office. **We will not be able to see the patient until a referral is received from the PCP's office.**

#### For Internal Use Only

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_  
Provider: \_\_\_\_\_ Location: \_\_\_\_\_  
Date Patient was Notified: \_\_\_\_\_ Date Referring Physician Office was Notified: \_\_\_\_\_  
Scheduler Signature: \_\_\_\_\_