VALLEY UROLOGY ◆Greg Rainwater M.D., Matthew Rainwater M.D., Chao Vang N.P.

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REFERRAL FORM

Date: _____

Patients Name: _____ DOB:_____

Patients Phone Number(s): _____ or _____

Referring Doctor: _____

Phone # _____ Fax # _____

Please Mark all that may apply for Patients Referral

- ☐ Kidney Stones
- ☐ Hematuria
- ☐ Elevated PSA
- ☐ Renal Mass
- ☐ Testicular Mass
- ☐ Retention/ Frequency/ Urgency
- ☐ Low Testosterone
- ☐ Prostate/ Bladder/ Kidney Cancer
- ☐ Elevated PSA
- ☐ BPH / Prostate Problems
- ☐ Urinary Tract Infections
- ☐ Stress/ Urge Incontinence
- ☐ Testicular Pain
- ☐ ED
- ☐ Vasectomies
- ☐ Infertility

Please Send Along with Referral :

- Copy of Insurance Cards (Front and Back)
- Patient Demographics
- Insurance Authorization
- All CT/ Ultrasounds/ Labs/ Chart notes relevant to the patient diagnosis

PLEASE ALLOW 5-7 DAYS FOR REFERRAL PROCESSING
Referrals Clerk: Manuel M.