CALIFORNIA UROLOGY

782 Medical Center Dr. East, Ste. 311, Clovis, CA 93611
(Main Office Phone) 559-472-4600 (Referrals Desk) 559-472-4607 (Fax) 559-472-4602

REFERRAL FORM

Date: _____

PLEASE PRINT AND INDICATE THE PATIENTS NAME AS IT APPEARS ON THE INSURANCE CARD

Patient Name	DOB	Phone
Address	City	Zip Code
Type of Insurance		
Requested Provider ☐ Thomas X. Minor, M.D. ☐ Nadeem Rahman, M.D.		
Diagnosis	Referring Physician	
Referral Contact	Phone	Fax

PLEASE NOTE REASON FOR REFERRAL:

☐ *STAT (Send pathology, lab, and imaging with patient who will bring CD and/or OP report with them to appointment.)
- ____PROSTATE CANCER
- ____KIDNEY CANCER
- ____BLADDER CANCER
- ____TORSION

☐ *ASAP
- ____KIDNEY STONES (Send imaging report)
- ____ELEVATED (PSA) Prostate Specific Antigen (Send lab)
- ____MISC UROLOGICAL MASSES_____

☐ *ROUTINE
- ____HEMATURIA
- ____URINARY TRACT INFECTION
- ____URINARY – INCONTINENCE
- ____SCROTAL or TESTICULAR PROBLEMS (Send ultrasound)
- ____INFERTILITY (send semen analysis)
- ____PROSTATE PROBLEMS
- ____ERECTILE DYSFUNCTION
- ____VASECTOMY

**********PLEASE INCLUDE THE FOLLOWING DOCUMENTATION WITH REFERRAL**********

- Insurance authorization and copies of the insurance card(s) (front and back).
- Patient demographics (Face Sheet)
- Physician progress notes, scans, and labs

Please fax the required information to our referrals fax number: 559-472-4602

FOR OFFICE USE ONLY: 1st Call_____ 2nd Call_____

Spoke with_____ and scheduled the following appointment on_____

Scheduled with: Dr. Minor_____ Dr. Rahman_____ on _____ at _____