

Urology

Referral Request

560 West Mitchell Street, Suite 340

Petoskey, MI 49770

Phone: 231 487-7303 / Fax: 810-600-7512

Referring Provider: _____ Phone: _____

Contact Person: _____ Fax: _____

Patient Name: _____ DOB: _____

Referrals will not be processed without a demographic sheet or proper information listed below

Primary Insurance: _____

Subscriber: _____ DOB: _____

Policy Number: _____ Group Number: _____

Does patient have Secondary Insurance? _____ Yes _____ No

Reason For Referral (Diagnosis): _____

ICD-10 Diagnosis Code: _____

THE RECORDS BELOW ARE REQUIRED BEFORE AN APPOINTMENT IS SCHEDULED:

- Most recent office visit note
- Current medication List
- Treatment History
- Social & Family History
- Lab Studies
- Radiological Studies that pertain to the issue for referral (acute stones, cancer, lesions, hematuria, hydronephrosis, urine retention)

Elevated PSA (x2 lab reports)

- No ejaculation 48 hours prior to the test
- No "straddling" type activity (i.e.- riding a bicycle, motorcycle) 48 hours prior to the test

Kidney Stones

- CT ABD/PEL

Renal Mass

- CT or MRI

Renal Cyst

- CT or MRI

UTIs

- Previous cultures
- Previous medications tried

Prostate cancer

- Path reports
- Previous treatment notes
- PSAs

Imaging within the last year (Please send films via mail or push to PACS at McLaren Northern Michigan Hospital)