

Patient Referral Intake Form
FAX TO: 803-457-7001

PLEASE MAKE SURE ALL PATIENT INFORMATION IS CORRECT!

Patient Name _____
DOB _____ SSN _____
Address _____
City _____ State _____ Zip _____
Home Phone: _____ Cell _____
Work _____

INSURANCE

Primary _____ ID# _____ Self/Spouse _____
Secondary _____ ID# _____ Self/Spouse _____
Spouse's Name _____ DOB _____ SSN# _____

REFERRAL INFORMATION

Referring MD _____ Phone# _____ Fax# _____
Contact _____ Contact# _____ Ext _____
Diagnosis _____ (reason for referral)

Has the patient had any bladder surgery in the past three years YES NO

***If YES – name/type of surgery _____

***Where was the surgery performed (hospital name) _____

***Doctor that performed the surgery _____ Surgery Dates _____

***Please send **last office notes** associated with **diagnosis** and copy of **Insurance Cards**. This will ensure that your patient will be scheduled with an appointment in a timely manner.

APPOINTMENT INSTRUCTIONS

***Southern Urogynecology will fax this form with the appointment time back to you to notify the patient, and for your records. Please advise patients there is a \$45.00 "NO SHOW" Fee for missed appointments not cancelled or rescheduled 48 hours in advance. This fee is for NEW patients.

***ALL NEW PATIENTS are required to report to our office 30 minutes prior to their scheduled appointment time. This will allow sufficient time to complete paperwork and the registration process. Please make sure your patient knows that they may see the Physician and/or the Physician Assistant at their visit.

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Appointment Date: _____ Appointment Time: _____ Arrival Time: _____
SCHEDULED WITH: _____

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