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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