

**UROLOGY** 

## Austin

1301 Barbara Jordan Blvd., Suite 302 Austin, TX 78723

Cedar Park 1301 Medical Pkwy., Suite 310 Cedar Park, TX 78613 Phone: (512) 472-6134

FAX: (512) 472-2928

After Hours: (512) 406-3112

childrensurology.com

## PATIENT REFERRAL REQUEST

☐ Jose C. Cortez, MD	☐ Vani S. Menon, MD, FAAP	☐ Amanda R. Hodge, RN, CPNP
☐ George M. Seremetis, MD	☐ Kelly J. Nast, MD	☐ Rachel S. Hernandez, PA-C
☐ Leslie T. McQuiston, MD	☐ Mary "Katie" Wang, MD	☐ First Available Provider
Referral Date:		
REFERRING PHYSICIAN/PROVIDER INFO	ORMATION	
Name:	Office Phone:	FAX #:
Name of office contact (if other than MD):		NPI #
PATIENT & FAMILY INFORMATION		
PATIENT First Name:	Last Name:	
Date of Birth:	☐ Male ☐ Female	
PARENT/GUARDIAN First Name:	Last Name:	
Phone:	Alternate Phone:	
Has the patient been seen by Children's Urolog	gy before? 🔲 Yes 🔲 No 🗀 Unknown	
CLINICAL INFORMATION		
Type of referral: ☐ Routine ☐ Urgent (fo	r urgent appointments, please call triage nurse)	
Diagnosis/Reason for referral:		
	Please provide supporting clinical documentation	ion
INSURANCE INFORMATION		
Patient Insurance Type:   Commercial PPO	□ Commercial HMO □ Private-Pay □ Medicai	d 🗅 Other
Insurance Carrier:	Policy ID#	

To expedite your referral, please complete this form and

FAX to (512) 472-2928