



782 Medical Center Dr. East, Ste. 311, Clovis, CA 93611
 (Main Office Phone) 559-472-4600 (Referrals Desk) 559-472-4602 (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 <input type="checkbox"/> Thomas X. Minor, M.D. <input type="checkbox"/> Nadeem Rahman, M.D. <input checked="" type="checkbox"/> Andrew Chi, M.D. <input checked="" type="checkbox"/> Anas Hamdi, M.D. <input checked="" type="checkbox"/> Zhoobin Bateni, 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 _____