



**** Consult / Referral Forms are now available on-line at www.cccahealth.com ****

1902 Moores Lane
Texarkana, Tx. 75503
Phone: (903) 614-3850
Fax: (903) 791-8645

UROLOGY CENTER

CONSULT (Request for advice / opinion) or **REFERRAL** (Request for management of care)
(Please only select one request)

REQUESTING PROVIDER INFORMATION

Requesting Provider Name Requesting Provider Address (street, city, state, zip)

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Requesting Provider Telephone Requesting Provider Fax Number NPI #

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APPOINTMENT REQUEST

DIAGNOSIS

First Available Jessie Liang, MD C. Todd Payne, MD Jason Pickelman, MD
 J. Sean Womack, MD Kaci Drumm, APRN, FNP-BC

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PATIENT and INSURANCE INFORMATION

Patient Name (First, Middle Initial, Last) Gender

| | |
|--|---|
| | <input type="checkbox"/> Male <input type="checkbox"/> Female |
|--|---|

Address City, State, Zip

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Date of Birth (mm/dd/yyyy) Social Security #

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Home Telephone Mobile Telephone Work Telephone

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Does patient need an interpreter? If yes, what language?

| | |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N | |
|---|--|

Does the patient have medical insurance? Name of Insurance Company and Plan Number (required for Yes)

| | |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N | |
|---|--|

DOCUMENTATION

Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 792-6950. Thank you in advance for the request and your cooperation.