CHOC Children's

Division of Urology Referral Request

Division Phone: 714.509.3919 CHOC Scheduling Line 888.770.2462 Fax: 855-246-2329

Thank you for referring your patient to the Division of Pediatric Urology.

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance : _____ Parent Cell: _____

1. Is this an **emergent** Urology referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD/PA/NP with clinical information to 714.509.3919**

2. Please describe the patient's chief complaint and *include onset and frequency*:

_____

_____

_____

Pre-referral work up requirements by diagnosis: please use the Urology Center Referral Guidelines to ensure your patient is ready for their appointment, http://www.choc.org/referralguidelines

To expedite appointment scheduling, please provide the following by FAX 866-529-9704:

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint and information requested on the Referral Guidelines**
- ☐ **Lab and test reports within the last year**
- ☐ **Patient demographics**
- ☐ **Authorization for consult 99245, or if not applicable, a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____

Provider Signature: _____ **Date:** _____ **Time:** _____