



CMCL Urology

2600 W. Pleasant Run Rd.
Lancaster, TX 75146
Ph: 888.817.7143
Fax: 888.776.1348

REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (888)776-1348

Referring Provider:	_____	Referring Office Name:	_____
Referring Provider Phone #:	_____	Office FAX #:	_____
Primary Care Provider:	_____	Today's Date:	_____
Person Completing Form:	_____	Patient's SSN:	_____
Patient's Name (F/MI/L):	_____		
Patient's Address:	_____		
Patient's Date of Birth:	_____	Patient's Phone #:	_____
Patient's Insurance/Auth #'s:	_____		
Reason for Referral (please be specific):	_____		

Please Note:

- We must have PSA's for all males over the age of 50. Please send the most recent Serum PSA on file.
- Please FAX any pertinent X-Ray or Lab reports along with this form.
- We will notify the patient by mail or phone of appointment time and date

Thank you for your referral. Please do not hesitate to call us with any questions or concerns.

Office Use Only
Provider: _____
Appointment Date: _____
Appointment Time: _____