New Patient Referral Form

1226 East Water Street, Syracuse NY 13210 Phone: (315) 478-4185 Fax: (315) 478-0840
North Medical Center 5100 West Taft Road, Suite 4D, Liverpool NY 13088 Phone: (315) 458-6669 Fax: (315) 458-0819
Northeast Medical Center 4211 Medical Center Drive, Suite 211, Fayetteville NY 13066 Phone: (315) 329-0210, Fax: (315) 329-0215
Medical Center West 5700 West Genesee Street, Suite 124, Camillus NY 13031 Phone: (315) 478-4185, Fax: (315) 478-0840
2 Ellinwood Drive New Hartford, NY 13413 Phone: (315) 724-1012 Fax: (315) 724-5219
357 Genesee Street, Suite 1 Oneida, NY 13421 Phone: (315) 363-8862 Fax: (315) 363-3326
192 Genesee Street Auburn, NY 13021 Phone: (315) 258-5253 Fax: (315) 258-0202
806 West Broadway Fulton, NY 13069 Phone: (315) 297-4700 Fax: (315) 218-5898
80 East Main St, Canton, NY 13617 Phone: (315) 714-2559 Fax: (315) 386-3056

Please fill out the form and provide a copy of the patient's medical records. **Fax to: 315-299-4707**
A.M.P. will contact the patient to schedule an appointment and notify you of appointment confirmation.

Date: _____ **Physician requesting:** _____

Patient's name _____ First Last Middle Initial			
Patient's address _____ Street City Zip			
Date of Birth:	SS#	Phone # (H)	Phone # (W)
Reason for referral:			
Previous X-rays? Yes No	X-ray Date: X-ray Place:	X-ray Results:	
PSA: Yes No Result:	*Patient in a nursing facility Yes No Is patient able to consent to Tx Yes No Is patient ambulatory Yes No*		
Is this an emergency? Yes No	Has patient seen previous urologist? Yes No		
Insurance Company:	Insurance prefix ID # Plan Name:		Referral Required Yes No
Patients Employer			

If you would like to be notified of the appointment arrangements made for this patient, please provide the following information:
Fax # *Attention:*

For use by Urology Consultants only

Appointment Date: Appointment Time: Appointment Location:		Appointment with:
X-rays ordered? Yes No	Date:	Place:
Information Packet Sent? Yes No	Made by:	Patient Contacted? Yes No
Dr. Reply:		