Urology
Alan M. Freedman, M.D.

Print, Complete and fax to (949) 645-0277

Physician Referral Form

Date____/____/____ Name of patient_____

Patient's Phone # _____

Insurance (Indemnity, Medicare, PPO, Cash, HMO/name of medical group)

_____

Nature of urologic problem _____

_____

Relevant studies (laboratory, radiographic-please attach)

_____

Comorbidities _____

Urgency of consultation _____

Specific GU questions you would like addressed

_____

_____

Name of physician _____

M.D.'s phone # _____