HAYSMED

Western Kansas Urological Associates

Request for Consultation, New Patient, or Self Referral

❑ *Consultation* ❑ *New Patient/Self Referral*

Patient Name:_____ Date:_____

DOB:_____ SSN:_____

(Minor) Parent Name:_____

Height:_____ Weight:_____

Phone Numbers Home:_____ Cell:_____ Work:_____

Address: _____

City State Zip Code

Requesting Physician:_____

Physician's Address:_____

City State Zip Code

Phone:_____ Fax:_____ Contact Person:_____

List person who notified Western Kansas Urological Associates

Does patient have any special needs?

❑ Interpreter needed
❑ Full lift
❑ Wheelchair bound
❑ Methicillin-resistant Staphylococcus Aureus (MRSA)/ Vancomycin-resistant Enterococcus (VRE)
❑ Other_____

Requested Physician:_____ or ❑ First Available

Reason for Consultation: _____

_____

Is the patient a Veteran? ❑ Yes ❑ No If yes, has a request of service (ROS) been sent? ❑ Yes ❑ No

Clinics: Please fax the following information with the complete form.

❑ Demographics ❑ Office Notes ❑ Lab Reports
❑ Imaging Reports - Cloud images to HaysMed if applicable

_____ _____

Signature of Person Completing Form Date/Time

Appointment Date:_____ Time:_____

Western Kansas Urological Associates 2214 Canterbury Drive, Suite 308 Hays, KS 67601 Phone: (785) 628-6014 Fax: (785) 625-4791	**HaysMed Specialty Clinic** 3515 Broadway Great Bend, KS 67530 Phone: (620) 796-2135 Fax: (785) 623-2273

Form # CLI 225
Revised 8/14, 8/14-1, 10/14, 7/15, 10/15, 1/17, 3/17, 8/18, 2/23, 6/25

DOB: D A/Sdt: