

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: _____

Physician's Address: _____ City _____ State _____ Zip Code _____

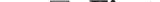
Phone: _____ Fax: _____ Contact Person: _____

Does patient have any special needs? _____
Last person who notified Western Kansas Urological Associates

Does patient have any special needs?

Interpreter needed Methicillin-resistant Staphylococcus Aureus (MRSA)/

Full lift Vancomycin-resistant Enterococcus (VRE)

Reported by:  Date:  File #: 

Requested Physician: _____ or First Available

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

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
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