



REFERRING TO:

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- FIRST AVAILABLE

ORDERING PHYSICIAN:

Physician's Name: _____ NPI #: _____

Address: _____

Office Phone: _____ Office Fax: _____

PATIENT INFORMATION:

Name: _____ DOB: _____

Patient Contact Phone Number: _____

DIAGNOSIS:

- | | |
|---|---|
| <input type="checkbox"/> Circumcision | <input type="checkbox"/> Urinary Incontinence/Frequency/Urgency |
| <input type="checkbox"/> Hernia/Hydrocele | <input type="checkbox"/> Nocturnal Enuresis/Bedwetting |
| <input type="checkbox"/> Phimosis/Foreskin Problems | <input type="checkbox"/> Urinary Tract Stones |
| <input type="checkbox"/> UDT (Undescended Testes) | <input type="checkbox"/> Vesicoureteral Reflux |
| <input type="checkbox"/> Varicocele | <input type="checkbox"/> Hydronephrosis |
| <input type="checkbox"/> Hypospadias/Chordee | <input type="checkbox"/> UPJ Obstruction (Ureteropelvic Junction) |
| <input type="checkbox"/> Penile Anomalies | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Neurogenic Bladder, Spina Bifida | <input type="checkbox"/> Kidney Tumors, Cysts, Hematuria |
| <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Other _____ |

PLEASE BRING: Current Medications Lab Results Radiology Reports Imaging Disc/CD

Insurance Provider: _____

Authorization #: _____

Physician's Signature: _____ Date: _____

PLEASE FAX PATIENT'S DEMOGRAPHICS, PROGRESS NOTES AND DIAGNOSTIC TEST RESULTS TO (210) 615-1601.

4499 MEDICAL DRIVE, SUITE 360
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