

**Mississippi Urology Clinic, PLLC**

Physician Referral Form

**Preference:**

**Jackson:** 501 Marshall St. Suite 301 Jackson, MS 39202

First Available Appointment (or select provider below)

\_\_Adams

\_\_Blalock / Stuart

\_\_Daily / Furr

\_\_Haraway / Lishman

\_\_Moss

\_\_Runnels / Amason

**Flowood:** 1040 River Oaks Dr. Suite 202 Flowood, MS 39232

First Available Appointment (or select provider below)

\_\_Adams / Loe

\_\_Haraway / Lishman

\_\_Hynes

\_\_Moss

**Magee:** \_\_ Adams (1<sup>st</sup> Tuesday of each month)

\_\_ Runnels (4<sup>th</sup> Wednesday of each month)

**Vicksburg:** \_\_ Adams (3<sup>rd</sup> Tuesday of each month)

**Carthage:** \_\_ Runnels (1<sup>st</sup> Wednesday of each month)

**Kosciusko:** \_\_ Moss (every Tuesday of each month)

**Hazlehurst:** \_\_ Blalock (3<sup>rd</sup> Wednesday afternoon of each month)

Patient Name: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy/Grp #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy/Grp #: \_\_\_\_\_

Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient SSN: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Patient Primary Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient Email: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_

Referring Clinic Name: \_\_\_\_\_

Referring Physician Address: \_\_\_\_\_

Referring Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\*\*\*\*\*PLEASE FAX REFERRAL FORM AND PATIENT'S MEDICAL RECORDS TO: (601) 353-3654\*\*\*\*\*

Telephone: 601-353-9900

Fax: 601-353-3654

Email: [mucreferrals@simpify.net](mailto:mucreferrals@simpify.net)