

Referral / New Patient Inquiry

ETCH Pediatric Urology
& The Brave Clinic



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Please complete the following and return along with the records.

Patient Name: _____ **DOB:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Parent/Guardian Name: _____ **DOB:** _____

Primary Insurance: _____ **ID#** _____

Policy Holder: _____

Secondary Insurance: _____

Referring Provider: _____ **Phone:** _____ **Fax:** _____

Reason for Referral: _____

Appointment needed ASAP? YES ___ **NO** ___ **Office note attached** _____

Does this patient need an interpreter? _____

*****If you have imaging on a disk please send with patients family*****

Appointment Date: _____ **Time:** _____ **Provider** _____

***We will complete the appointment information and return it to you as soon as possible. Please include the office notes for the referral and copy of insurance card. ***