Alberta Health Services

Urology Central Intake Referral

This form is for **NON-URGENT adult urology** referrals only.
Fax to 403.592.4250

For **URGENT** matters, call RAAPID at 403.944.4486 or Switchboard at 403.943.3000 to page the Urologist on call.

Confirm patient's current address before affixing label.

Name *(last first)*	
PHN / HRN	Phone
Address	
Gender	Date of Birth *(yyyy-Mon-dd)*

Requested Provider

☐ Appropriate provider assigned by intake protocol
☐ Specific surgeon or clinic/previous urologist
Name _____
Comments _____
☐ This referral is for 2nd opinion

Emergency Department Only

Urologist on Call _____
Contacted? ☐ Yes ☐ No
☐ Acute Stone Clinic Referral *(Clinic referral form required)*
ED Physician _____
GP/FD _____

Referral Guidelines

☐ Attach referral letter and results of relevant investigations
Guidelines for recommended investigations can be located on the Alberta Referral Pathways website:
https://www.albertahealthservices.ca/assets/info/hp/arp/if-hp-arp-cz-urology-qr.pdf

Adrenal

☐ Mass ☐ Other _____

Bladder/Incontinence

☐ Bladder mass on imaging
☐ Overactive bladder
☐ Incontinence
☐ Recurrent UTIs
☐ Neurogenic bladder
☐ Elevated PVR/retention
☐ Fistula
☐ Other _____

Fertility

☐ Abnormal semen analysis
☐ Family planning *(vasectomy request)*
☐ Vasectomy reversal request
☐ Other _____

Hematuria

☐ Gross hematuria
☐ Microhematuria *(greater or equal to 3 RCBs/HPF)*

Kidney and ureter

☐ Renal mass
☐ Renal cyst
☐ Hydronephrosis
☐ Stone, symptomatic or with obstruction
☐ Stone, asymptomatic
☐ Other _____

Penis

☐ Foreskin problems
☐ Cancer concern
☐ Peyronie's disease/penile curvature
☐ Other _____

Prostate

☐ Male lower urinary tract symptoms *(LUTS)*
☐ Elevated PSA or abnormal DRE
☐ Prostatitis
☐ Other _____

Scrotum

☐ Hydrocele/spermatocele/varicocele
☐ Other _____

Sexual function/andrology *(Male)*

☐ Sexual dysfunction ☐ Low testosterone
☐ Erectile dysfunction
☐ Other _____

Testis

☐ Testicular mass ☐ Pain *(orchalgia)*
☐ Microlithiasis ☐ Other _____

Urethra

☐ Female urethral disorder
☐ Male urethral disorder
☐ Other _____

Vagina

☐ Pelvic organ prolapse
☐ Other _____

Other relevant clinical details *(include referral letter)*

Referral Source Name	Prac ID	Phone	Fax	Date *(yyyy-Mon-dd)*