High-Resolution Anoscopy (HRA)

Referral Form

Please fill out the information below, attach a signed HIPAA waiver and anal cytology result and fax to our coordinator at **212-819-6998.**

Date of Referral:_____

Referring Provider Name:_____

Referring Institution:_____

Provider Phone:_____ **Fax:** _____

Provider Email:_____

Patient Name:_____

Date of Birth:_____

Home Address:_____

Phone Number(s):_____

Insurance Type:_____

Policy #:_____

Anal Pap Smear Date: _____

Result: ☐ ASC-US ☐ ASC-H ☐ LSIL ☐ HSIL ☐ Other:_____

Comments:

_____

_____

In-Office Use Only:

Date Received: _____ Date of Scheduled HRA:_____

Date Patient Notified: _____ Notification Via: ☐ Phone ☐ Letter