CARILION CLINIC UROLOGY
120 Akers Farm Rd., Christiansburg, VA 24073
Phone: (540) 382-3440

Specialty Provider Appointment Request Form

** Please complete and return this cover sheet along with your referral to fax (540) 382-8406.*
Total pages (including this form): _____

Referring Doctor Information:

Date Requested: _____ Referring Doctor: _____ Office Contact: _____
Contact Phone #: _____ Office Fax #: _____

Patient Information:

Patient Name: _____ Date of Birth: _____ SS#: _____
Home Phone #: _____ Cell #: _____ Work #: _____

If the patient is a minor, please provide:

- **Responsible Party Name:** _____**Relation:** _____
- **Alternate Contact Phone (if different):** _____**Alternate Cell #:** _____

Required Documents Checklist

To avoid scheduling delays, please include the following documents with your referral.

- **Reason for Referral:** _____
- **Copy of Insurance Card(s)** (front and back)
- **Current Medication List**
- **All Relevant Office Notes & Labs** for the patient's referral
  - Urine analysis: Yes _____ No _____ If no, please provide reason: _____
  - Urine cultures: Yes _____ No _____If no, please provide reason: _____
  - All imaging and reports: Yes _____ No _____If no, please provide reason: _____

(Note: Imaging should be pushed to PACS at CNRV before the patient is scheduled.)

Additional Information

- **Previous Urologist:** Yes _____ No _____
  - If yes, please provide name and send available records: _____
- **Other Providers Seen for This Referral:** Yes _____ No _____
  - If yes, please list providers and send available records: _____

☐ *This issue may be resolved more quickly through an e-consult or direct communication between the PCP and urology provider. If an e-consult or direct provider communication would be beneficial, please either:*

- *Submit an e-consult request (for Carilion providers), or*
- *Provide a contact number for phone communication.* _____

Please indicate if treatment algorithms are attached: have / have not (circle one).

Additional Records Request

Upon initial review, if further records are needed, we will indicate those below and fax this form back to your office. Please fax the additional records using this form as the cover sheet.

- **Requested Additional Records:** _____
- **Date:** _____

Upon receipt of all requested records, we will contact the patient directly to schedule the appointment. Thank you!