CARILION CLINIC

Urogynecology and Pelvic Floor Physical Therapy Appointment Request Form

Please fax all pertinent medical records including gyn/incontinence/prolapse operative reports, urinalysis results, urine cultures, recent pap results, renal ultrasounds, or other imaging with request, and if possible, have images pushed to Sectra.

PATIENT INFORMATION

Patient Name (First, MI, Last): _____

Date of Birth: _____ Preferred language: _____

Address: _____

Telephone (Home): _____ (Cell): _____ (Work): _____

Insurance Coverage: _____ ID#: _____

Work Comp or VA Referral? ☐ Yes ☐ No Is an insurance referral required? ☐ Yes ☐ No
Referral Number: _____

Appointment Requested (please circle):

☐ **Urogynecology Consult/Establish Care**

☐ **Pelvic Floor Physical Therapy**

Reason for Referral (please circle):

☐ Stress Incontinence ☐ OAB/Urge Incontinence ☐ Bladder Fistula ☐ Rectovaginal Fistula

☐ Prolapse Desiring Surgery ☐ Prolapse Desiring Pessary ☐ Recurrent UTI ☐ Bladder Pain ☐ Pelvic Pain

☐ Hematuria ☐ Fecal Incontinence ☐ Lichen Sclerosis ☐ Vaginal Atrophy ☐ Vaginal Cyst ☐ Specialty Review

Priority of Appointment (please circle one below):

☐ **Urgent** ☐ **See w/in 2 days** ☐ **See w/in 7 days** ☐ **See w/in 14 days** ☐ **Routine**

Please fax the referral cover sheet and medical records to 540-985-4069.
For same day work in, please call 540-985-4099 and ask for the Urgent Nurse Line

First Available or Specific Provider: _____

REFERRING PHYSICIAN OFFICE INFORMATION

Provider Referring the Patient: _____

We will contact the office below via fax to notify you of the appointment request outcome.

Office Contact Name: _____ Contact Fax Number: _____

Revised 06.2024