UNC Health Care has an online referral portal, UNC CareLink!

Enroll online at http://unccarelink.org/

Questions? Email unccarelink@unchealth.unc.edu or Call the Carolina Consultation Center at (800) 862-6264.

Adult Urology Referral Fax Cover Sheet

TO: (Please check beside the desired location)

- [ ] UNC Hospitals Urology Services located at:
  - [ ] UNC Medical Center: 984-974-5289 (Fax) / 984-974-1315 (Phone)
  - [ ] Carolina Point I (CP I): 984-974-5289 (Fax) / 984-974-1315 (Phone)
  - [ ] NC Cancer Hospital: 919-843-5016 (Fax) / 984-974-8235 (Phone)

- [ ] UNC Urology at Hillsborough: 919-595-5668 (Fax) / 919-595-5927 (Phone)

- [ ] UNC Urology at Siler City: 919-799-4051 (Fax) / 919-799-4050 (Phone)

FROM:

Name: _________________________________________________________

Practice: _______________________________________________________

Phone #: _________________________ Fax #: _________________________

# of Pages (including cover pages): ______

______________________________

Patient Name: ___________________________________________________

Patient Preferred Phone Number: __________________________________________

Patient DOB: _______________________________________________________

Patient MRN: _______________________________________________________

(Please provide UNC MR Number (MRN) if patient has been seen here before. If he/she doesn’t have one, we can register the patient at the time we schedule the appointment)
Reason for Referral:
- Kidney Stones
- Hematuria (Blood in Urine)
- Urinary Incontinence
- Erectile Dysfunction
- Benign Prostatic Hyperplasia (BPH)/Enlarged Prostate
- Vasectomy
- Hernia Repair
- Bladder Infection
- Urinary Tract Infections
- Elevated PSA
- Suspected Cancer (please specify) ____________________________
- Other (please specify) ____________________________

Referring Physician Name: _____________________________________________________

Referring Physician Practice: ___________________________________________________

Contact Person (person completing this form): ____________________________________

Insurance Information:
- Private Insurance (please specify): ____________________________
- Medicare (please specify, if supplement): ____________________________
- Medicaid
- Self-Pay

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