Marble Valley Urology
A Department of Rutland Regional Medical Center
145 Allen Street, Rutland, VT 05701
802.775.6006 | 802.773.4946 fax | www.RRMC.org

REFERRAL FORM

Name:_____ DOB:_____ SSN:_____
(last 4 digits)

Address:_____

Preferred Phone:_____

Primary Insurance Name:_____ Policy #_____ Group #_____

Secondary Insurance Name:_____ Policy #_____ Group #_____

DIAGNOSIS/REASON FOR VISIT:_____
Must be included to schedule appointment.

Referring MD:_____

Fax #:_____ Phone#:

Primary Care Physician:_____
(If different than referring provider listed above)

Service Appointment Requested (choose one): ❑ Urgent ❑ Routine

Special Needs: (Wheelchair, transfer assist, etc.) _____

Appointment Preferences: Day of Week_____ ❑ AM ❑ PM

PLEASE PROVIDE PERTINENT OFFICE NOTES, LABS, X-RAY REPORTS AND MEDICATION LISTS

Please complete and fax referral form to 802.773.4946

Appt. Date:_____ **Appt. Time:**_____ **MVU Staff to Return to Provider via Fax**

Patient Label