

UROGYNECOLOGY & PELVICE RECONSTRUCTIVE SURGERY REQUEST FOR PATIENT EVALUATION AND/OR SURGICAL CONSULTATION

Referral date: _____

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone # (H): _____ (Cell or work): _____

SSN: _____ Emergency contact/phone: _____

Primary Insurance Co: _____ Name of insured: _____

Policy #: _____ Group #: _____ Precertification/referral #: _____

Secondary Insurance Co: _____ Policy #: _____ Group #: _____

REFERRING PROVIDER INFORMATION:

Referring Physician: _____ Office Contact: _____

UPIN #: _____ Office phone: _____ Fax: _____

REASON FOR REFERRAL CHECK ALL THAT APPLY:

- | | |
|--|--|
| <input type="checkbox"/> Surgical Consultation | <input type="checkbox"/> Mesh or sling problems |
| <input type="checkbox"/> Pelvic prolapse | <input type="checkbox"/> Fecal/bowel incontinence |
| <input type="checkbox"/> Cystocele / Rectocele / Enterocele | <input type="checkbox"/> Recurrent Prolapse or Incontinence |
| <input type="checkbox"/> Uterine prolapse | <input type="checkbox"/> Urinary voiding dysfunction |
| <input type="checkbox"/> Vaginal vault prolapse | <input type="checkbox"/> Overactive bladder |
| <input type="checkbox"/> Mixed incontinence | <input type="checkbox"/> Fistula |
| <input type="checkbox"/> Stress or urge incontinence | <input type="checkbox"/> Anorectal manometry / Endoanal ultrasound |
| <input type="checkbox"/> Interstim treatment | <input type="checkbox"/> Urodynamics |
| <input type="checkbox"/> Posterior tibial nerve electric stimulation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pelvic organ prolapse research | |
| <input type="checkbox"/> Cystourethroscopy | |

Specific physician: No (first available) Yes (Dr. _____)

PATIENT HISTORY:

Diagnosis prompting consultation: _____

Surgical history: _____

Specific concerns that you would like addressed: _____

***All pertinent records such as prior operative notes should be received prior to scheduling of appointment.**

Receipt of records prior to the appointment for other evaluations is strongly encouraged in order to maximize information that can be provided to your patient. Please fax appropriate records to (205) 996-3167. If you have any questions please call (205) 996-3130.

Please attached the following: • Operative notes • Last clinic note • Pelvic ultrasound/imaging
• Cytology/endometrial biopsy results