UROGYNECOLOGY & PELVIC 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):

☐ Surgical consultation
☐ Pelvic prolapse
☐ Cystocele/rectocele/enterocele
☐ Uterine prolapse
☐ Vaginal vault prolapse
☐ Mixed incontinence
☐ Stress or urge incontinence
☐ InterStim Therapy
☐ Posterior tibial nerve electric stimulation
☐ Pelvic organ prolapse research
☐ Cystourethroscopy
☐ Mesh or sling problems
☐ Fecal/bowel incontinence
☐ Recurrent prolapse or incontinence
☐ Urinary voiding dysfunction
☐ Overactive bladder
☐ Fistula
☐ Anorectal manometry/endoanal ultrasound
☐ Urodynamics
☐ Other ____________________

Specific physician: ☐ No (first available) ☐ Yes (Dr. ____________________)
Preferred location: ☐ UAB campus ☐ St. Vincent's ☐ Grandview

PATIENT HISTORY:

Diagnosis prompting consultation: ______________________________

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Surgical history: ______________________________

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Specific concerns that you would like addressed: ______________________________

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***All pertinent records, such as prior operative notes, should be received prior to scheduling the 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 attach the following:

- Operative notes
- Last clinic note
- Pelvic ultrasound/imaging
- Cytology/endometrial biopsy results

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