Dartmouth Health

Dartmouth Hitchcock Clinics

Phone: (603) 695-2500
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Urogynecology | Reconstructive Pelvic Surgery

Please check one: ❑ Urgent - Fax to (603) 640-1909 ❑ Stable - Fax to (603) 676-4080

Symptoms: _____

How long has patient been symptomatic? _____

Past pelvic/incontinence surgery? _____

Is this worker's comp related? _____

Diagnosis: (Please check all that apply and circle all known conditions)

❑ **Pelvic organ prolapse** (Uterine prolapse, vaginal prolapse, cystocele, rectocele, enterocele, unknown)

❑ **Urinary incontinence:** (Stress incontinence, overactive bladder, mixed, frequency or urgency, overflow incontinence, functional incontinence, unknown)

❑ **Voiding dysfunction** (Urinary retention, difficulty voiding, unknown)

❑ **Anal incontinence** (Neurogenic, sphincter damage, unknown)

❑ **Difficulty with defecation**

❑ **Genitourinary fistula** (Vesicovaginal fistula, rectovaginal fistula, unknown)

Reason for request: (Please check one)

❑ **Second opinion**

❑ **Evaluation and treatment** of condition.

❑ **Evaluation of condition only**, with recommendations for management. Return patient to referring office for treatment.

❑ **Evaluation of condition and treatment only for specific recommendations:** (i.e., for urodynamic testing only; or for pessary fitting only with ongoing at referring office; or only if certain surgeries are recommended – please specify what you want us to treat versus what you would treat) _____

❑ **Other**: _____

_____