

Office Use Only

Provider: _____

Appt. Date: _____

POL & HQUEST info given: _____

Testing: _____

Notes: _____

Urogynecology/Reconstructive Pelvic Surgery

Request for Evaluation

Phone: (603) 653-9312

Fax: (603) 650-0902

Urgent: call Physician Connection Line at 1-866-346-2362 or 603-653-9312

Stable

Please complete patient information below, or attach patient demographic information before faxing.

Patient's Name: Last _____ First _____ MI _____

DOB: _____ SSN: _____ - _____ - _____ MR #: _____

Address: _____ City, ST: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Name of Insurance: _____ ID #: _____ Insurance Referral Required? Yes No

Referring Provider: _____ Office Phone: _____

Contact Name: _____ Office Fax: _____

Address: _____

Would you like notification of the appointment? Yes No

Symptoms: _____

How long has patient been symptomatic? _____

Past pelvic/incontinence surgery? _____

Is this Worker's Comp related? No Yes

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

- | | |
|--|---|
| <input type="checkbox"/> Pelvic organ prolapse (uterine prolapse, vaginal prolapse, cystocele, rectocele, enterocele, unknown) | <input type="checkbox"/> Voiding dysfunction (urinary retention, difficulty voiding, unknown) |
| <input type="checkbox"/> Urinary incontinence (stress incontinence, overactive bladder, mixed, frequency or urgency, overflow incontinent, functional incontinence, unknown) | <input type="checkbox"/> Anal incontinence (neurogenic, sphincter damage, unknown) |
| <input type="checkbox"/> Difficulty with defecation | <input type="checkbox"/> Genital fistula (vesicovaginal fistula, rectovaginal fistula, unknown) |

Reason for request (please check one):

- Consultation regarding condition(s) above and management options.
- 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): _____

- Referral to evaluate and treat condition(s) above. Second opinion

Before faxing this referral form, please check the following information which is included so that we may process your referral in a timely fashion.

- | | | |
|---|--|--|
| <input type="checkbox"/> Pertinent records from prior surgeries | <input type="checkbox"/> Op notes | <input type="checkbox"/> Prior evaluations and/or testing (i.e., urinalysis, urine cultures, urodynamic testing, etc.) |
| <input type="checkbox"/> Insurance referral (if required) | <input type="checkbox"/> Medical history | |