Dartmouth-Hitchcock

Referral Form for Family Planning Services

Obstetrical and Gynecological Department
One Medical center Drive
Lebanon, NH 03756

Patient Name______________________________ Patient DOB: __________ Age:____ MRN: _____________________________

Maiden Name____________________ PCP:____________________ Patient SSN: ____

Address: ____

Home Phone:_____________________ Cell Phone: _______________________Can messages be left regarding care? Yes ❒No❒

Alternative Contact Name: ____________________Phone: ________________ Can messages be left regarding care? Yes ❒No❒

Marital Status: _____________________________Partners Name: ____

Referring Provider Name: ____________________________________ Date of referral: ___________________________________

Genetic Counselor: ____ GC Phone:_______________________________________

Office Address: ____ Office Phone: ____________________________________

____ Office Fax: _______________________________________

Medical History

Procedural Indication: Medical❒ Social❒: ____

G: ________ P: __________ Patient's Gestational Age Today: _________ w ________ d

LMP: ______________ Ultrasound: ______w _________d on ___________ EDD: _____________________

Blood Type: _____________ Height: ______________ Weight: ______________ Allergies: __________________________

Significant Obstetrical History (including dates for C/S Birth):____

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Significant Medical/Social History: ____

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Care Coordination❒Footprints (>16w) ❒POC Analysis ❒Chaplaincy ❒Child Life ❒Funeral Disposition

Additional Resources____

Please fax all pertinent medical and ultrasound records:
Nurse Coordinator Phone: 603-653-9404
Surgical Coordinator Phone: 603-653-9238
Fax: 603-650-0901