Dartmouth Health

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):_____

_____

Significant Medical/Social History: _____

_____

Please fax all pertinent medical and ultrasound records:
Nurse Coordinator Phone: 603-653-9300
Fax: 603-640-1918