

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 | |