Dartmouth-Hitchcock
MEDICAL CENTER

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):

❑ Pelvic organ prolapse (uterine prolapse, vaginal prolapse, cystocele, rectocele, enterocele, unknown)
❑ Urinary incontinence (stress incontinence, overactive bladder, mixed, frequency or urgency, overflow incontinent, functional incontinence, unknown)
❑ Difficulty with defecation
❑ Voiding dysfunction (urinary retention, difficulty voiding, unknown)
❑ Anal incontinence (neurogenic, sphincter damage, unknown)
❑ 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.

❑ Pertinent records from prior surgeries
❑ Insurance referral (if required)
❑ Op notes
❑ Medical history
❑ Prior evaluations and/or testing (i.e., urinalysis, urine cultures, urodynamic testing, etc.)