UROGYNECOLOGY & PELVICE RECONSTRUCTIVE SURGERY REQUEST FOR PATIENT EVALUATION AND/OR SURGICAL CONSULTATION

Referral date: ____________________

PATIENT INFORMATION:

Patient Name: ____________________ DOB: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone # (H): ____________________ (Cell or work): ____________________

SSN: ____________________ Emergency contact/phone: ____________________

Primary Insurance Co: ____________________ Name of insured: ____________________

Policy #: ____________________ Group #: ____________________ Precertification/referral #: ____________________

Secondary Insurance Co: ____________________ Policy #: ____________________ Group #: ____________________

REFERRING PROVIDER INFORMATION:

Referring Physician: ____________________ Office Contact: ____________________

UPIN #: ____________________ Office phone: ____________________ Fax: ____________________

REASON FOR REFERRAL CHECK ALL THAT APPLY:

☐ Surgical Consultation
☐ Pelvic prolapse
☐ Cystocele / Rectocele / Enterocele
☐ Uterine prolapse
☐ Vaginal vault prolapse
☐ Mixed incontinence
☐ Stress or urge incontinence
☐ Interstim treatment
☐ Posterior tibial nerve electric stimulation
☐ Pelvic organ prolapse research
☐ Cystourethroscopy
☐ Mesh or sling problems
☐ Fecal/bowel incontinence
☐ Recurrent Prolapse or Incontinence
☐ Urinary voiding dysfunction
☐ Overactive bladder
☐ Fistula
☐ Anorectal manometry / Endoanal ultrasound
☐ Urodynamics
☐ Other ____________________

Specific physician: ☐ No (first available) ☐ Yes (Dr. ____________________)

PATIENT HISTORY:

Diagnosis prompting consultation: ____________________

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Surgical history: ____________________

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Specific concerns that you would like addressed: ____________________

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***All pertinent records such as prior operative notes should be received prior to scheduling of appointment.** Receipt of records prior to the appointment for other evaluations is strongly encouraged in order to maximize information that can be provided to your patient. Please fax appropriate records to (205) 996-3167. If you have any questions please call (205) 996-3130.

Please attached the following:
- Operative notes
- Last clinic note
- Pelvic ultrasound/imaging
- Cytology/endometrial biopsy results