

Women's Institute Referral Form
Gyn/UroGyn

Patient Name: _____ DOB: ____ / ____ / ____
Home phone: _____ Alternate phone: _____
Address: _____ City: _____ Zip: _____
Insurance Company: _____ Precertification? Y or N Authorization #: _____
Referring Practice: _____ Referring MD _____ Office Contact: _____
Referring Phone: _____ Referring Fax: _____
Is an interpreter needed? Y or N If yes, what language? _____

GYN INDICATIONS

- Gynecologic ultrasound _____
- Colposcopy / lower genital tract disease
- Dysplasia of cervix, vulva, or vagina
- Vulvovaginal disorder _____
- Laparoscopic gynecologic surgery
- Contraception _____
- Pediatric/adolescent gynecology
- Evaluation of uterine fibroids
- Evaluation of abnormal uterine bleeding
- Evaluation of ovarian cyst
- Polycystic Ovarian Syndrome
- Other: _____

REFERRING PHYSICIAN PRACTICE: Patient records must be forwarded and received by the Women's Institute 1 week prior to scheduled appointment. Please send at minimum (as applicable):

- Records from last office visit
- Lab and Pathology results
- Imaging/test results
- Operative notes

UROGYN INDICATIONS

- Incontinence
- Pelvic Organ Prolapse (new evaluation)
- Pelvic Organ Prolapse (previous surgery)
- Interstitial cystitis / Painful Bladder Syndrome
- Pelvic Pain
- Pelvic Reconstructive Surgery
- Presurgery consult – complex laparoscopic
- Other: _____

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- Lab and Pathology results
- Imaging/test results
- Operative notes

office use only:

SSN: _____ Hx : _____ Mailed Packet: _____
Appt date: _____ Time: _____ Physician: _____