FAX REFERRAL REQUEST

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Referrals can be made by faxing this form or calling the office.

Date: _____ Number of Pages: _____

Name: _____ DOB: _____

Cell Number: _____ Home or Work Number _____

Insurance Company Name: _____

Insurances may require pre-authorization

Name of Insured: _____ Policy Number: _____

Reason for consult _____

Indication based on ICD-10:

- ☐ R39.89 Bladder Pain
- ☐ N30.10 Chronic Interstitial Cystitis
- ☐ R15.9 Fecal incontinence
- ☐ R35.0 Frequency of micturition
- ☐ R35.1 Nocturia
- ☐ R39.198 Other difficulties with micturition
- ☐ R10.2 Pelvic and perineal pain
- ☐ N99.3 Post hysterectomy prolapse
- ☐ R33.9 Retention of urine
- ☐ N39.46 Stress Urge Incontinence
- ☐ N39.41 Urge Incontinence
- ☐ R39.15 Urgency of urination
- ☐ N81.4 Uterovaginal prolapse
- ☐ N81.10 Vaginal prolapse
- ☐ N82.0 Vesicovaginal fistula

Enclosed Records:

- ☐ Colonoscopy
- ☐ EMB
- ☐ Pap Smear
- ☐ Sonogram
- ☐ Urine Culture

Signature of Ordering/Referring Physician: _____

Printed Name: _____ Date: _____

Referring Contact: _____ Phone: _____ Fax: _____

* INTERNAL USE ONLY *

Appointment Date: _____ Time: _____ Medical Record #: _____