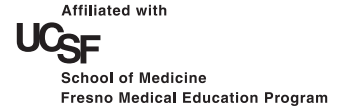


FAX REFERRAL REQUEST

University | Urogynecology Associates



Anubhav Agrawal, M.D.

1530 Shaw Ave, Clovis, CA 93611
Phone: 559.908.9270 | Fax: 559.320.0558
www.UniversityMDs.com

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:

- Bladder Pain, Chronic Interstitial Cystitis, Fecal incontinence, Frequency of micturition, Nocturia, Other difficulties with micturition, Pelvic and perineal pain, Post hysterectomy prolapse, Retention of urine, Stress Urge Incontinence, Urge Incontinence, Urgency of urination, Uterovaginal prolapse, Vaginal prolapse, 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 #: \_\_\_\_\_