GYNECOLOGY REFERRAL FORM

Healthy Women's Care

Date: ___/___/_____

Patient Information

Last Name: _____ First Name: _____
DOB (MM/DD/YYYY): _____
Telephone: _____ Email:_____

Referring Physician

Physician Name: _____Specialty: _____
Office Address: _____
Telephone: _____ Fax:_____

Reason for Referral

- ○ Abnormal uterine bleeding
- ○ Amenorrhea / Menstruation dysfunction
- ○ Annual Health Exam
- ○ Colposcopy
- ○ Contraception management
- ○ Dysmenorrhea
- ○ Endometrial Biopsy
- ○ Endometriosis
- ○ Fibroids/polyps
- ○ Genital malformation
- ○ Genital prolapse
- ○ Infection / STDs
- ○ IUD insertion/ removal
- ○ Menopause management
- ○ Ovarian cyst or tumor
- ○ Pap smear, Cervical Cancer Screening
- ○ Pelvic pain
- ○ Polycystic Ovarian Syndrome (PCOS)
- ○ Sonohysterograms *[uterine cavity, tubal patency]*
- ○ Urinary incontinence
- ○ Vulvar/vaginal cyst or tumor
- ○ Other_____

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