Date: _____

UroGynecology
SPECIALTY CENTER
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION

Tara K. Brah, MD

Fellowship Trained & Board Certified
Minimally Invasive Gynecologic Surgery

REFERRAL FORM
PATIENT DEMOGRAPHICS

PLEASE PRINT AND INDICATE THE PATIENTS NAME AS IT APPEARS ON THE INSURANCE CARD(S)

Patient Name	**DOB**	**Phone**
Address	City	Zip Code
Type of Insurance		

Please select Diagnosis(s):

☐ Abdnormal Uterine Bleeding ☐ Uterine Septum ☐ Endometriosis

☐ Fibroids ☐ Adenomyosis ☐ Adnexal cyst ☐ Polyps

☐ Cesarean Scar Defects ☐ Other _____

Referring Physician:

Referral Contact	Phone	Fax

PLEASE INCLUDE THE FOLLOWING DOCUMENTATION (IF POSSIBLE)

- Demographics sheet and copies of the insurance card(s) (front and back)
- Physician progress notes and labs
  Radiology reports including CT, MRI, ultrasound, x-ray, etc.

PLEASE NOTE:

- Please allow our office 72 hours to respond. Appointments will be scheduled upon receiving completed request. We will contact the patient to schedule an appointment with our office.

Scheduling contact information (fax all correspondence to the number below):
Phone: 559 321-3012 Fax: 559 321-2940

*****PATIENT WILL ONLY BE SCHEDULED ONCE COMPLETED REFERRAL IS RECEIVED*****