Date: ____________________

UroGynecology
SPECIALTY CENTER
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & PART OF SANTE HEALTH FOUNDATION
Female Pelvic Medicine & Reconstructive Surgery
Fellowship Trained & Board Certified Specialists

Benjamin Steinberg, DO, FACOG **Jason Meade, DO, FACOOG**

Tara Brah, MD, FACOG

Gloria Lovering, NP-C **Kaitlyn Crouch, PA-C** **Deborah McBride NP**

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): ☐ Urinary Incontinence ☐ OAB ☐ Pelvic Organ Prolapse (cystocele/rectocele)
☐ Recurrent UTI's ☐ Pelvic Pain ☐ Vaginal Atrophy ☐ Interstitial Cystitis ☐ Female Sexual Dysfunction

☐ Viveve Consult ☐Other ____

☐ **MIGS- Dr. Tara Brah** ☐Abnormal uterine bleeding ☐Endometriosis ☐Fibriods ☐Adnemoysis ☐Polyps
☐Adnexal Cyst ☐Cesarean Scar Defects ☐Uterine Septum.

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*****

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