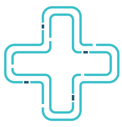

Randy Yarbrough, MD
Nichole Brooks, CRNP
1948 AL Highway 157, POB 1, Suite 330
Cullman, AL 35058
Phone: (256) 735-5277 FAX: (256) 203-8626

GYNECOLOGY REFERRAL FORM

Patient's Name: ______________________________

DOB: ______________ Phone #: ______________ Cell #: ______________

Address: ______________________________

Insurance Carrier: ______________________________

Policy #: ______________________________

Referral authorization # if required ______________________

Please include clinical documentation such as lab work, clinic notes, if available.

1. Is this an emergent gynecology referral? ☐ No ☐ Yes (If Yes, please explain)

____

2. Please describe the patient's chief complaint and *include onset and frequency*:

____
____
____
____

3. Has the patient had a hysterectomy? ☐ No ☐ Yes
4. Is the patient on Hormone Replacement Therapy? ☐ No ☐ Yes

Additional Comments: ______________________________

To expedite appointment scheduling, please provide the following by fax: (256) 203-8626

☐ This completed form ☐ Most recent office note
☐ Medical Records related to chief complaint
☐ Lab & test results within the last year
☐ Prior Authorization, or if not applicable, a copy of insurance card

Referring Provider: ______________________________

Provider Address/Location: ______________________________

Phone #: ______________ Fax #: ______________

Provider Signature: ______________________ **Date:** ______________

Appointment Date/Time: ______________ Patient notified on: ______________

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures