CULLMAN REGIONAL | Medical Group

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OBSTETRICS/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