



CULLMAN
REGIONAL

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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