



UROGYNECOLOGY CONSULTATION FORM

(Please Print)

Today's Date ____/____/____

Referring Physician _____

Contact Name _____ Phone _____

Contact Fax _____

PATIENT INFORMATION

| | | | | | | |
|---------------------|------|-------|----------|------------------------|-------------------|------------------------------|
| Patient's Last Name | | | First | Middle | Birth Date / / | |
| Address | City | State | ZIP Code | Social Security Number | | Home Phone Number () |
| | | | | | | Cell Phone Number () |
| | | | | | | Employer Phone Number () |

BILLING INFORMATION (PLEASE SUBMIT A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD)

Insurance Type

Cash
 PPO
 HMO
 Medicare
 MediCal
 Other

| | | |
|--|---------|----------|
| Secondary Insurance | Group # | Policy # |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, specify carrier name _____ | | |

CONSULTATION SPECIFICS

Indication _____

CHECKLIST OF REQUIRED INFORMATION TO BE PROVIDED VIA FAX – 559.322.2901

Labs
 Ultrasound
 Progress Notes
 Billing Information
 Other

NOTES

FWMG RESPONSE

| | | |
|-------------------------------------|---|--|
| Appointment Date/Time | <input type="checkbox"/> Patricia Felton, MD <input type="checkbox"/> Janene Jarrett, NP | Mark items received <input type="checkbox"/> Labs <input type="checkbox"/> Ultrasound <input type="checkbox"/> Progress Notes <input type="checkbox"/> Billing Information |
| Date/Time Faxed to Referring Office | Patient Informed by FWMG <input type="checkbox"/> Yes <input type="checkbox"/> No Date/Time _____ | FWMG Initials |
| Diagnosis | Provider Initials | Plan <input type="checkbox"/> CMG <input type="checkbox"/> Stims x _____ <input type="checkbox"/> KCL Testing <input type="checkbox"/> Other _____ |

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