Pelvic Floor Center

Progressive Research. Advanced Diagnostics. Innovative Treatments. ®

PATIENT REFERRAL / TESTING ORDER FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Telephone: _____ Cell: _____

REFERRING PROVIDER INFORMATION

Provider Name: _____ Clinic Name: _____

Office Telephone: _____ Office Fax: _____

Clinical Contact: _____ Phone: _____

STEP 1: DIAGNOSIS – PLEASE CHECK ALL THAT APPLY

TESTING PERFORMED ACCORDING TO SPECIALTY DEFINED DIAGNOSIS PROTOCOL

Accidental Bowel Leakage
Constipation
Rectal Pain
Pediatric Patient
(Testing Only)

High Resolution Anoscopy Clinic
____ Abnormal Anal Pap Results
____ Anal / Rectal Polyps

Prolapse:
____ Rectal
____ Rectocele

Ultrasound Clinic
____ Fistula / Abscess
____ New Dx Anal / Rectal Cancer
____ Follow-Up Anal / Rectal Cancer

Urogynecology
Urinary Incontinence
Prolapse
____ Vaginal / Uterine
____ Cystocele
Pelvic / Vaginal Pain

STEP 2: PLAN OF CARE – PLEASE CHECK PREFERENCE

Testing Only
Patient Will return to referring provider to discuss results of testing and a treatment plan

Testing and Consult
Patient will consult with applicable pelvic floor specialists for review of test results and treatment plan

Testing then Biofeedback if Indicated
Patient will undergo pelvic floor testing only and will return to referring provider for results. We will schedule biofeedback if indicated by testing.

Biofeedback
Patient does not need any pelvic floor testing or consultation. Patient referred for biofeedback only.

STEP 3: PROVIDE RELEVANT MEDICAL RECORDS

PATIENT WILL BE SCHEDULED ONCE RECORDS HAVE BEEN RECIEVED

Medical Records Attached

Records will be sent once complete

Records available on Excellian / Fairview
MRN: _____

STEP 4: ADDITIONAL COMMENTS OR CONSIDERATIONS

11/17/16 slp

FAX COMPLETED FORM TO: (651) 312-1570