

Progressive Research. Advanced Diagnostics. Innovative Treatments. $_{\hbox{$\mathbb{R}$}}$

PATIENT REFERRAL / TESTING ORDER FORM

PATIENT INFORMATION	
Patient Name: Date o	f Birth:/ Language:
Telephone:Insurance Name 8	≩ ID:
REFERRING PROVIDER INFORMATION	
Provider Name:	
Clinic Name:	Specialty:
Office Telephone:	Office Fax:
STEP 1: DIAGNOSIS — PLEASE CHECK ALL THAT APPLY TESTING PERFORMED ACCORDING TO SPECIALTY DEFINED DIAGNOSIS PROTOCOL	
 □ Fecal Incontinence/Accidental Bowel Leakage □ Constipation/Obstructive defecation □ Rectal Pain □ Prolapse: Rectal 	☐ <u>Ultrasound Clinic</u> Fistula / Abscess New Dx Anal / Rectal Cancer Follow-Up Anal / Rectal Cancer ☐ <u>High Resolution Anoscopy Clinic</u> Abnormal Anal Pap Results
Rectocele Enterocele	Anal / Rectal Polyps
STEP 2: PLAN OF CARE - PLEASE CHECK ONE PREFERENCE	
 ☐ Testing Only Patient will return to referring provider to discuss results of testing and a treatment plan ☐ Testing and Consult 	 □ Pediatric Patient (under 18 years old) Patient will undergo anal manometry and emg testing only, then return to referring provider for results. □ Biofeedback
Patient will consult with applicable pelvic floor specialists for review of test results and treatment plan	Patient does not need any pelvic floor testing or consultation. Patient referred for biofeedback only. *we do not offer biofeedback for urogynecology symptoms
STEP 3: PROVIDE RELEVANT MEDICAL RECORDS PATIENT WILL BE SCHEDULED ONCE RECORDS HAVE BEEN RECIEVED	
☐ Medical Records Attached ☐ Records will be sent onc	e complete
STEP 4: ADDITIONAL COMMENTS OR CONSIDERATIONS	