Fresno Women's Medical Group

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 INSRUANCE CARD)

Insurance Type

☐ Cash ☐ PPO ☐ HMO ☐ Medicare ☐ MediCal ☐ Other _____

Secondary Insurance	Group #	Policy #
❑ Yes ❑ 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	☐ Felton, MD ☐ Miller, NP	Mark items received ☐ Labs ☐ Ultrasound ☐ Progress Notes ☐ Billing Information
Date/Time Faxed to Referring Office	Patient Informed by FWMG ☐ Yes ☐ No Date/Time _____	FWMG Initials
Diagnosis	Provider Initials	Plan ☐ CMG ☐ Stims x_____ ☐ KCL Testing ☐ Other _____

CHECKLIST

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Obstetrics and Gynecology
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