THE University of Vermont MEDICAL CENTER

MRN

Name

DOB

PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY REFERRAL INTAKE

Urogynecology	Vulvovaginitis	Colon & Rectal Surgery
☐ Diane Charland, MD	☐ Tracey Maurer, MD	☐ Krista Everett Evans, MD
☐ Rebecca Shaffer, MD	☐ Elizabeth Bonney, MD	☐ Jeremy Dressler, MD
☐ Jeanette Rivera, MD	**Urology**	
☐ Kaitlin Brenny, PA-C	☐ Urzsula Kowalik, MD	

MRN/SS #_____Address: _____

Patient Telephone: (Home) _____ (Cell) _____ (Work) _____

Insurance provider (required) _____ ID # _____

Telephone: _____ is prior authorization required by insurance for this consult? ☐ Yes ☐ No

If yes, please provide authorization Number: _____

PLEASE CONFIRM THAT THE PATIENT IS CURRENTLY ELIGIBLE WITH THEIR INSURANCE PLAN ☐ Yes ☐ No

It is the responsibility of the referring office to obtain the prior authorization for our consult appointment

Referring Provider: _____PCP:_____

Phone: _____ Fax: _____Office Contact Name: _____Diagnosis: _____

Please provide the following information:

☐ Patient's demographics ☐ Surgical Op Notes ☐ Office Notes

Imaging Studies? ☐ Yes ☐ No Images sent ☐ yes ☐ no

Patient scheduled: _____ Patient notified: Letter Sent ☐ Phone/Voicemail ☐
(Date and time of appointment)

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