THE University of Vermont MEDICAL CENTER

Referral intake form to Continence Center

Urogynecology	**Vulvovaginitis**	**Urology**
☐ Diane Charland, MD	☐ Tracey Maurer, MD	☐ Gillian Stearns, MD
☐ Rebecca Shaffer, MD	☐ Elizabeth Bonney, MD	**Colon & Rectal Surgery**
☐ Jordan Tolstoi, PA		☐ Krista Everett Evans, MD

Patient Name____D.O.B__________________________

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 PATINET IS CURRENTLY ELIGIBLE WITH THEIR INSURANCE PLAN ☐ Yes ☐ No

<u>It is the responsibility of the referring office to obtain the prior authorization for our consult appointment</u>

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)

The Continence Center Medical Office Building, Fanny Allen Campus 792 College Parkways Suite 101 Colchester, VT 05446
Phone: 802-847-5800 Fax: 802-847-4151

Form # 036761 (7/2017)