

PHYSICIAN REFERRAL FORM

To ensure clear communication for the treatment of CRPM patients, please complete this form and fax to the clinic coordinator. The clinic coordinator will assist patients in scheduling appointments with other CRPM members. Please include any medical records when referring patients. For purposes of record keeping, all patients should be registered with this office. Thank you for your assistance in treating patients.

PATIENT INFORMATION

NAME LAST		FIRST	MI	DOB MM/DD/YYYY
ADDRESS (OR ATTACH DEMOGRAPHIC SHEET)		HOME PHONE	WORK PHONE	CELL PHONE
INSURANCE	ID	GROUP	CUST SVC #	

CONSULTATION WITH CRPM PHYSICIAN: SELECT SPECIALIST

<input type="checkbox"/> Colon & Rectal	<input type="checkbox"/> Pelvic Reconstructive Surgery	<input type="checkbox"/> Gynecology	<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Intimacy Counseling	<input type="checkbox"/> Urology	<input type="checkbox"/> Urogynecology
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Physician Requesting (Optional):

REASON FOR REFERRAL

<input type="checkbox"/> Anal Fissure / Hemorrhoids	<input type="checkbox"/> Hormone Replacement Therapy	<input type="checkbox"/> Post Prostatectomy Incontinence
<input type="checkbox"/> Cancer (Please Specify):	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Pre / Post Prostatectomy
<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> Male Pelvic Floor Dysfunction	<input type="checkbox"/> Recurrent Urinary Tract Infections
<input type="checkbox"/> Chronic Pelvic Pain	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Rectal Pain / Levator Spasm
<input type="checkbox"/> Dysparunia / Vaginal Pain	<input type="checkbox"/> Neurogenic Bladder	<input type="checkbox"/> Urinary / Rectal Fistulas
<input type="checkbox"/> Enlarged Prostate	<input type="checkbox"/> Overactive Bladder	<input type="checkbox"/> Urinary Frequency / Urgency / Urge Incontinence
<input type="checkbox"/> Fecal Incontinence	<input type="checkbox"/> Pelvic Organ Prolapse	<input type="checkbox"/> Urinary Incontinence / Mixed Incontinence / Stress Incontinence
<input type="checkbox"/> Female Sexual Dysfunction	<input type="checkbox"/> Pelvic Pain	<input type="checkbox"/> Vaginal Absence Deformities

Other (Please Specify):

NOTICE: This list is merely a reference intended to be used as a guideline to assist in identifying the reason for the referral. It is not an all inclusive list and none of the above may apply to your patient.

PLEASE FAX THIS FORM TO 713.441.0248
WE WILL CONTACT THE PATIENT THE SAME DAY OR NEXT WORKING DAY

PHYSICIAN'S NAME	PHONE	FAX
PHYSICIAN'S SIGNATURE	OFFICE CONTACT PERSON	DATE/TIME