WakeMed
Physician Practices
wakemedphysicians.com

UROGYNECOLOGY
Women's Center

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REQUEST FOR REFERRAL

Referring Practice/Provider: _____

Date of Request: _____ Same Day Request? ☐ Yes ☐ No

Patient Name: _____ DOB: _____

Patient's Preferred Contact Number: _____

G: _____ P: _____

Patient Preferences (Date/Time): _____

Reason for Referral *(Please circle)*		
Childbirth Trauma	Painful Intercourse	Urinary Incontinence
Cystocele	Pelvic Organ Prolapse	Urinary Retention
Enterocele	Rectocele	Vesicovaginal Fistulae
Fecal Incontinence	Rectovaginal Fistulae	Vulvar Dystrophy
Mesh Complications	Sexual Dysfunction	Voiding Difficulty
Overactive Bladder	Other: _____	

Specific question(s) to be addressed in consultation: _____

_____

_____

Patient is scheduled for practice appointment/procedure on _____

Faxed notification of practice appointment/procedure to referring provider on _____

by _____

Using the phone and fax numbers from the top of this form, please call for an appointment or fax this request to our office (along with appropriate records, notes, lab results, insurance info where applicable). Thank you for your referral. To download this form electronically, visit wakemedphysicians.com and click on "Referring Providers."