Complex Contraception Clinic

REQUEST FOR SERVICES

UNIVERSITY WOMEN'S HEALTH SPECIALISTS

Phone: (808) 203-6561 Fax: (844) 811-9548

Please fax completed forms to our office along with pertinent medical records.

We will call the patient directly to schedule an appointment.

Thank you for referring your patient to our practice.

1. **Indicate requested service (choose one):**

☐ **One-time consult for a specific contraceptive need or problem. Please specify problem or question(s):**

Would you like the Family Planning physician to:

☐ Provide contraceptive method to patient

☐ Evaluate and make recommendations only

☐ **Consult and ongoing co-management of particular contraceptive need(s). Please specify questions or problem(s) you would like the Family Planning physician to manage**:

☐ **Pre- or inter-conception counseling. Please specify problem or question(s**):

☐ **Full transfer of all ob-gyn care**

2. **May we make additional referrals to other specialty care as needed?**

☐ Yes ☐ No, consult referring provider first

3. **How do you want to be contacted with recommendations/follow up?**

☐ Consult note in EPIC ☐ Page/phone call. Number:

☐ Progress note faxed to office. Fax Number:

4. Patient Information:

Name: ________________________________Phone Number(s): __________________

Address: ____

Insurance:

Subscriber ID:

Subscriber Name Subscriber DOB

Date of Birth: ________ **Age:** ______ **G:** _____ **P:** _____ **LMP:** ________

Office use only : Appt Date : Appt Time :

5. Referring Provider: _______________________________

Address: ________________________________ City__________________ Phone: ___________________ Fax: _______________

Contact Person: ________________ **Referring Provider Signature:** ____