UNIVERSITY WOMEN'S HEALTH SPECIALISTS

John A. Burns School of Medicine Faculty Practice
Women's Option Center
1329 Lusitana St., POB2 Suite 703, Honolulu, HI 96813

REFERRING PROVIDER NAME _____ **CONTACT PHONE#**_____

TELEPHONE [_____] _____-_____ FAX [_____] _____-_____

PATIENT NAME _____ , _____ **DOB** _____ / _____ / _____

MRN [IF APPLICABLE]:_____ **PT CONTACT # [_____] _____-_____**

LMP _____ / _____ / _____ **GESTATIONAL AGE** _____ **BASED ON** _____

INSURANCE _____ **ID#** _____, **INSURANCE** _____ **ID#** _____
***Note: Please submit a copy of your patient's insurance card(s) with this referral and a valid State ID.**

Note: If you are referring an HMO patient and NOT the PCP or part of the HMO Health Center/Network, we will need a Referral or Authorization based on the Insurance Requirement to accompany this referral. For claim filing purposes, we need the complete name of the Referring provider, please do not enter a Clinic or Health Center Name.

REFERRAL/AUTHORIZATION INFORMATION:
Contact person: _____ **contact ph # [_____] _____-_____**
Referral/Auth # (if applicable) _____
Start Date _____ / _____ / _____ **End Date** _____ / _____ / _____
Note: Please submit a copy of the Insurance Authorization/Referral

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I AM SENDING PATIENT FOR THE FOLLOWING:

☐ **TERMINATION OF PREGNANCY :**_____ procedure requested

☐ **CONTRACEPTIVE COUNSELING:**_____device requested if applicable

☐ **STERILIZATION – LAPAROSCOPIC or HYSTEROSCOPIC [circle one]**

☐ **OTHER :** _____

PLEASE SPECIFY ONE:

☐ **CONSULT** ☐ **CONSULT & TREAT** ☐ **CONSULT, TREAT & FOLLOW-UP**
For termination patients, please indicate if you would like to see patient back for contraceptive counseling. If not, we routinely see patients for post-op, follow-up and counseling.

INCLUDED IN THIS FAX ARE THE FOLLOWING:

☐ **LABS**

* **ABO/Rh**	_____
* **CBC PLT W/DIFF**	_____
Gonorrhea	_____
Chlamydia	_____
Rubella	_____

☐ **ULTRASOUND** [must include measurements that meet requirements for ultrasound]
Date _____ / _____ / _____

GESTATIONAL AGE _____ **EDD** _____ / _____ / _____