



Women's Medicine Collaborative

A program of The Miriam Hospital
Lifespan. Delivering health with care.

Center for Women's Gastrointestinal Medicine
146 West River St. Providence, RI 02904
Phone: 793-7080 Fax: 793-7801

Program for Pelvic Floor Disorders ~ REFERRAL FORM

PATIENT _____ DOB ____ / ____ / ____

ADDRESS _____

HOME _____ CELL _____ WORK _____

May we leave a message stating the call is from "Women's Medicine Collaborative", "GI Medicine" or "Dr. ____'s office"? Yes No

PRIMARY INSURANCE _____ ID# _____

SECONDARY INSURANCE _____ ID# _____

REFERRING PROVIDER _____ PHONE _____ FAX _____

Patient is: NON-PREGNANT PREGNANT POSTPARTUM POST-OP ____ weeks

Translator needed? No Yes - Language Spoken: _____

REASON FOR REFERRAL:

- | | | |
|--|---|---|
| <input type="checkbox"/> Fecal incontinence | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Pelvic organ prolapse | <input type="checkbox"/> Dysmenorrhea |
| <input type="checkbox"/> Recurrent UTIs | <input type="checkbox"/> Postpartum pelvic floor issues | <input type="checkbox"/> Chronic ovarian cysts |
| <input type="checkbox"/> Interstitial cystitis/
Painful bladder syndrome | <input type="checkbox"/> Rectal prolapse and fistulas | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Bladder dysfunction secondary to
Nerve damage or neurologic injury | <input type="checkbox"/> Anal fissures | <input type="checkbox"/> Postpartum |
| | <input type="checkbox"/> Cystocele/Rectocele | <input type="checkbox"/> Post-op ____ weeks |
| | <input type="checkbox"/> Uterine prolapse | <input type="checkbox"/> Pelvic congestion syndrome |
| | | <input type="checkbox"/> Sexual dysfunction/Pain |
| | | <input type="checkbox"/> Pelvic floor myalgias/spasms |
| | | <input type="checkbox"/> Vulvodynia |
| | | <input type="checkbox"/> Vaginismus |
| | | <input type="checkbox"/> Unknown/Other:
_____ |

DETAILS /CHIEF COMPLAINT

**Fax with any pertinent records, OR reports & lab/test results to: 401-793-7801.
Our office will contact the patient to schedule an appointment.**

Thank you.