ST. ANTHONY

Urogynecology Referral Form

311 South Clark Street
PO Box 628
Carroll, Iowa 51401
Phone: (712) 792-2222
Fax: (712) 792-3875
www.stanthonyhospital.org

Form 1056
Rev. 07/26

Thank you for your referral to St. Anthony Clinic, Urogynecology.
A referral request has been reviewed for the patient listed below.

Today's Date: _____
(MM/DD/YYYY)

Patient First & Last Name: _____ Date of Birth: _____
(MM/DD/YYYY)

Patient Phone: _____ _____ _____
HOME: 123-456-7890 CELL: 123-456-7890 WORK: 123-456-7890

Referring Provider Name: _____ Phone: _____ _____
123-456-7890 FAX: 123-456-7890

Primary Care Provider Name: _____ Phone: _____ _____
If different than referring provider 123-456-7890 FAX: 123-456-7890

- ☐ Referral has been accepted. Our schedulers will contact patient to make an appointment.
- ☐ We are sorry to inform you the referral request has been declined. Thank you for considering us in the care of your patient.
- ☐ Please fax records that are indicated below if you have them so an appointment can be scheduled as soon as possible. If you have no further records please indicate and fax back.

Records Request: Please provide the following and check what is being sent:

- ☐ Current medication list
- ☐ Gyne pathology reports
- ☐ Previous pap smear
- ☐ Mammograms
- ☐ Labs (pertaining to referral)
- ☐ Uro/Gyne operation report
- ☐ Radiology reports (pertaining to referral)
- ☐ Gyne physician notes
- ☐ Colonoscopy report

☐ We do not have any further records on this patient.

Patient Barriers: Language, transportation, physical (hard of hearing, cannot stand, etc.)

_____

Additional Notes:

_____

_____

Please fax all additional records to (712) 792-3875

If you have any questions or concerns, please call (712) 792-2222.
Thank you for the opportunity to care for your patients.