Women's Medicine Collaborative*
Lifespan. Delivering health with care.™

146 West River Street
Providence, RI 02904
Phone: 401-793-5700
Fax: 401-793-7801
WomensMedicine.org

Back Line for Physician Office Use
OB Med/Pulm/Rheum: 401-793-7485
GI: 401-793-7486
Behavioral Med: 401-793-7489
Primary Care: 401-793-7487
Cancer Services: 401-793-7485

Referral Form

Fax with any pertinent records and lab/test results to: 401-793-7801 ~ Thank you.

PATIENT _____ DOB _____ /_____ / _____

ADDRESS _____

_____

PHONE Home _____ Cell _____ Work _____

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

PRIMARY INSURANCE _____ ID# _____

SECONDARY INSURANCE _____ ID# _____

REFERRING PROVIDER _____ PHONE _____ FAX _____

Urgency of Consult: ○ Within 24-48 hours ○ Within 1-2 weeks ○ Routine Appointment

REASON FOR REFERRAL

_____

Patient is: ☐ NON-PREGNANT ☐ PRECONCEPTION ☐ PREGNANT (EDD: _____ or Gest. Age _____ wks) ☐ POSTPARTUM

Translator needed? ☐ No ☐ Yes - Preferred Language: Spoken _____ Written _____

☐ Multidisciplinary **Obstetric Medicine** Service (MOMS)

- ○ Asthma/Pulmonary disorder
- ○ Cardiac disease
- ○ Diabetes *(Please use Diabetes in Pregnancy Program form**)*
- ○ GI disorder
- ○ Headache/Syncope/Seizures
- ○ Hematology disorder
- ○ Hepatitis
- ○ HTN
- ○ Hyperemesis
- ○ Maternal-Fetal Medicine
- ○ Palpitations/SOB
- ○ Postpartum Risk Assessment
- ○ Preconception Counseling
- ○ Renal disease
- ○ Rheumatology disorder
- ○ ROAD to a Healthy Pregnancy (Reducing Obesity And Diabetes)
- ○ Thyroid disorder
- ○ Other _____

☐ Behavioral Medicine

- ○ Mood/Anxiety disorders during pregnancy or postpartum
- ○ Mental Health Preconception Consult
- ○ Menopause
- ○ Premenstrual Syndrome
- ○ Other _____

☐ Cancer Services

○ GYN Oncology ○ Breast Cancer ○ Cancer Survivorship Program ○ High Risk Cancer Surveillance

Diagnosis: _____

☐ Genetic Counseling

Reason for Referral: _____

☐ Gastrointestinal Consult

- ○ C. Diff
- ○ Constipation
- ○ Diarrhea
- ○ Fecal Incontinence
- ○ Hepatitis
- ○ Hyperemesis
- ○ Inflammatory Bowel/Celiac disease
- ○ Irritable Bowel Syndrome
- ○ Liver disease
- ○ Other: _____
- ○ Colonoscopy/Endoscopy *(Please use Colonoscopy-Endoscopy Booking Sheet**)*
- ○ Bacterial Overgrowth test
- ○ Lactose Breath test

☐ Pulmonary Consult

○ Asthma ○ Sleep Apnea ○ Other Pulmonary disorder ○ Pulmonary Function Testing *(Please use PFT form**)*

☐ Rheumatology Consult

Reason for Referral: _____

☐ Nutrition Counseling

Reason for Referral: _____

☐ Bone Densitometry Testing *(Please use Bone Density Testing form**)*

☐ Testing Services

- ○ Bone Densitometry Testing *(Please use Bone Density Testing form**)*
- ○ Pulmonary Function Testing *(Please use PFT form**)*
- ○ Echocardiogram
- ○ Bacterial Overgrowth test
- ○ Lactose Breath test

☐ PT/Rehabilitation Services

For referrals, please call 793-7022.

**Additional referral forms are available for download at WomensMedicine.org