Women's Health Services
Referral / Consultation

Fax: 210-702-4205

Email: MFM@uhtx.com
GynOnc@uhtx.com
UroGyn@uhtx.com

University Health

Proudly partnering with
UT Health San Antonio

Preferred Physician (*optional*): _____

1. Is the patient pregnant? ☐ YES ☐ NO *(skip to question 5)*
2. **OB Service:** ☐ OB Diabetic Care ☐ Maternal Fetal Medicine ☐ Prenatal Services
3. Reason for Referral: ☐ Consult & Treat ☐ Co-Management ☐ Transfer of Care ☐ Other: _____
4. Priority: ☐ Routine ☐ Urgent (2-3 days)

5. **GYN Service:** ☐ Gyn Onc ☐ Uro Gyn ☐ Reproductive Endocrinology & Infertility (REI)
6. Reason for Referral: ☐ Consult & Treat ☐ Perform Procedure ☐ Other: _____
7. Priority: ☐ Routine ☐ Urgent (2-3 days)

OB CLINICAL DETAILS:

LMP:____ / ____ / ____ G:_____ P:_____

EDC: ____ / ____ / ____ by: _____LMP _____Scan

ULTRASOUND:

☐ Level I (Standard) ☐ GYN Vaginal

☐ Level II (Detailed) ☐ GYN Abdominal

☐ Biophysical Profile ☐ Fetal Echo

☐ NT Ultrasound ☐ Other _____

DIAGNOSIS OR ICD CODE: _____

COMMENTS _____

Please attach relevant medical records, prenatal records and previous ultrasound results related to the reason for referral.

Referring Provider _____ Date of Referral: _____ / _____ / _____

Referring Clinic _____ Provider NPI #: _____

Referring Clinic Callback #_____ Fax # _____ Contact Person_____

PATIENT DEMOGRAPHICS

Patient Name _____ DOB _____

Patient's Current Address _____

Home Phone_____ Mobile Phone _____

Last 4 of SSN #_____ MRN _____ Primary Language _____

PATIENT INSURANCE INFORMATION (Please include a copy of patient's insurance)

Referral Authorization # _____ Insurance Company _____

Policy Holder Address _____ Policy Holder's DOB _____

Policy/ID # _____ Group Plan # _____ Employer _____

Refer directly using www.myepiclink.com

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