THE University of Vermont MEDICAL CENTER

Referral Intake Form to Gynecology/Oncology

____Cheung Wong ____Elise Everett ____No Preference

Patient Name: _____

Date of Birth: _____ MRN: _____

Address: _____

Patient Telephone: (Home) _____(Cell)_____(Work)_____

THIS BOX *MUST BE COMPLETED* BEFORE AN APPOINTMENT CAN BE SCHEDULED

Insurance Provider_____ID#: _____
Telephone:_____Is prior authorization required by insurance for this consult? ☐ Yes ☐ No

If Yes, please provide authorization number:_____

PLEASE CONFIRM THAT THE PATIENT IS CURRENTLY ELIGIBLE WITH THEIR INSURANCE PLAN ☐ YES ☐ NO
It is the responsibility of the referring office to obtain the prior authorization for our consult appointment

Referring Provider: _____PCP:_____

Phone: _____Fax:_____

Office Contact Name: _____

The Referring Office will be notified of the appointment so that they may contact the patient

Diagnosis: _____

Is Patient aware of diagnosis? ☐ Yes ☐ No

Please provide copies of the patient's demographics, medical/surgical history, office notes, list of medications and allergies.

Imaging Studies? ☐ Yes ☐ No

Patient to hand carry images? ☐ Yes ☐ No Imaging sent? ☐ Yes ☐ No

Pathology Sides? ☐ Yes ☐ No Slides sent? ☐ Yes ☐ No

PLEASE FAX ALL RELEVANT RECORDS AND INFORMATION WITH THIS INTAKE FORM TO 802-847-0496