HAYSMED

Center for Women's Health

Request for Consultation, New Patient, or Self Referral

2214 Canterbury Drive, Suite 210 | Hays, KS 67601 | 785.623.5806 | FAX: 785.623.2343

❑ *Consultation* ❑ *New Patient/Self Referral*

Patient Name:_____ Date:_____

DOB:_____ SSN:_____

Phone Numbers Home:_____ Cell:_____ Work:_____

Address: _____

City State Zip Code

Requesting Physician:_____

Physician's Address:_____

City State Zip Code

Phone:_____ Fax:_____

Reason for Consultation:

_____

_____

Is the patient a Veteran? ❑ Yes ❑ No If yes, has a request of service (ROS) been sent? ❑ Yes ❑ No

_____ _____

Signature of Person Completing Form Date/Time

Appointment Date:_____ Time:_____

Clinics: Please fax the following information with the completed form.

- ❑ Last visit note
- ❑ Lab reports from the last year and last pap smear
- ❑ All relevant imaging from the last 6 months; if CT completed, will need pelvic US ordered by referring provider
- ❑ Current and complete medication list

DOB: D A/Sdt: