

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

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

