URINARY INCONTINENCE FAX REFERRAL FORM

TO: Maureen Brennan, PT
(312) 563-2454 (Mon, Weds)
Fax: 563-2222
Voice Mail: 312-942-9855

Deborah Wallace, OT
(312) 942-7173
Fax: 942-3601

FROM: _____

_____

Preferred Method of Contact:
Pager ___
Phone___
E-Mail___
Fax:___

DATE: ____/____/_____

PATIENT:

DIAGNOSIS 728.2 Muscular Wasting Deconditioning 728.85 Muscle Spasm 728.9 Unspecified d.o. of Muscle, Fascia

CLINICAL IMPRESSION: Stress Incontinence Urge Incontinence Overflow Mixed

REQUEST FOR CONSULTATION: [ ] Initial Evaluation [ ] 2 Visits per week x 4 weeks

HISTORY: (*If preferred, you may attach a copy of H&P from patient's chart)*

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CURRENT MEDICATIONS

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IMPORTANT: PLEASE HAVE PATIENT COMPLETE THE FOLLOWING FORMS AND BRING THEM TO THEIR FIRST APPOINTMENT!!!!

[ ] Bladder Questionnaire [ ] Pharmacia Bladder Diary (*at least 3 different days!)*

Also forward any copies of any of the following diagnostic studies (if done):

[ ] Urinalysis [ ] Urine Cultures [ ] Post Void Residual [ ] Cystometrics [ ] IVP-VCU [ ] Ultrasound

PLEASE RETURN A WRITTEN EVALUATION TO THE REFERRING PHYSICIAN LISTED ABOVE WITHIN 72 HOURS OF SEEING THIS PATIENT. IF YOU NEED TO REACH ME DIRECTLY, PLEASE PAGE _____.

_____

Physician