SJVSC South Jersey Vascular Surgery Center

Uterine Fibroid Embolization

CONSULTATION REQUEST

Patient Name: _____ Today's Date: _____

Patient Address: _____ Patient Phone: _____

Patient Height: _____ Patient Weight: _____ Patient Date of Birth: _____

Reason:

☐ Heavy menstrual bleeding ☐ Pelvic pain/pressure

☐ Frequent Urination ☐ Constipation

Clinical Information:

X-Ray contrast allergy: Yes ☐ No ☐ Reaction? _____

Blood Thinners: Yes ☐ No ☐ List Medications _____

Competent to sign consent: Yes ☐ No ☐ If no, whom: _____ Phone: _____

Transportation:

Does patient have someone f or transportation? Yes ☐ No ☐

Pelvic Ultra sound? Yes ☐ No ☐

Supportive Diagnostic Testing:

MRI Pelvis? Yes ☐ No ☐

****please attach final reports for above diagnostic testing****

Referring Physician: _____ **Phone:** _____

FAX FORM WITH PATIENT DEMOGRAPHICS, INSURANCE CARDS, CURRENT LABS, MEDICATION LIST, HISTORY AND PHYSICAL TO 856-482-9399 FOR SCHEDULING

South Jersey Vascular Center - 200 Century Parkway, Suite E, Mt. Laurel, NJ 08054 – (P) 856-482-2800 (F) 856-482-9399