GYN SURGERY
REFERRAL FORM

William Groves MD
OBSTETRICS AND GYNECOLOGY

1890 W. Gauthier Road, Suite 130
Lake Charles, LA 70605

Office (337) 480-5530 Fax (337) 480-5531

PATIENT INFORMATION

NAME: ______________________ DATE OF BIRTH: __________

PRIMARY CARE PHYSICIAN: ______________________

CURRENT OB/GYN: ______________________

INSURANCE COVERAGE: ______________________

CONTACT PHONE NUMBER: ______________________

WE DO NOT ACCEPT MEDICAID (PRIMARY OR SECONDARY) FOR WELLNESS OR GYN CARE.

GYNECOLOGICAL INFORMATION

GYNECOLOGICAL PROBLEMS/ CONCERNS ______________________

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PRIOR TREATMENTS (MEDICAL OR SURGICAL FOR THE ABOVE): ______________________

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LIST ALL PRIOR SURGERIES: ______________________

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PRIOR LAB OR IMAGING RELATED TO GYN PROBLEMS: ______________________

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J. William Groves, Jr., MD

PREGNANCY HISTORY

NUMBER OF PREGNANCIES: ____________________ NUMBER OF DELIVERIES: ____________

TYPE OF DELIVERY: VAGINAL ________ CESAREAN ________ LARGEST BIRTH WEIGHT: ____________

NUMBER OF MISCARRIAGE OR OTHER PREGNANCY LOSSES: __________

DESIRE FOR FUTURE CHILDBEARING: YES NO

PREGNANCY COMPLICATIONS OR COMMENTS: ______________________________

MEDICAL INFORMATION

CHRONIC MEDICAL PROBLEMS (such as heart disease, diabetes, high blood pressure, etc.): ____________

DAILY MEDICATIONS: ______________________________

BLOODWORK (ANEMIA, ETC.): ______________________________

ULTRASOUND OR OTHER IMAGING RESULTS: ______________________________

MOST RECENT PAP TESTS & RESULTS: ______________________________

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