CENTER FOR RESTORATIVE PELVIC MEDICINE
6560 FANNIN ST
HOUSTON, TX 77030
PHONE: (713) 441-5800 / FAX: (713) 791-5023
Email: pelvichealth@tmhs.org
www.methodistpelviccenter.com

PHYSICIAN REFERRAL FORM

To ensure clear communication for the treatment of CRPM patients, please complete this form and fax to the clinic coordinator. The clinic coordinator will assist patients in scheduling appointments with other CRPM members. Please include any medical records when referring patients. For purposes of record keeping, all patients should be registered with this office. Thank you for your assistance in treating patients.

PATIENT INFORMATION

NAME LAST	FIRST	MI	DOB MM/DD/YYY

ADDRESS (OR ATTACH DEMOGRAPHIC SHEET)	HOME PHONE	WORK PHONE	CELL PHONE
INSURANCE	**ID**	**GROUP**	**CUST SVC #**

CONSULTATION WITH CRPM PHYSICIAN: SELECT SPECIALIST

☐ Colon & Rectal	☐ Pain Management	☐ Gynecology	☐ Plastic Surgery	☐ Intimacy Counseling	☐ Urology	☐ Urogynecology

☐ Physician Requesting (Optional):

REASON FOR REFERRAL

☐ Anal Fissure / Hemorrhoids	☐ Hormone Replacement Therapy	☐ Post Prostatectomy Incontinence
☐ Cancer (Please Specify):	☐ Irritable Bowel Syndrome	☐ Pre / Post Prostatectomy
☐ Chronic Constipation	☐ Male Pelvic Floor Dysfunction	☐ Recurrent Urinary Tract Infections
☐ Chronic Pelvic Pain	☐ Muscle Weakness	☐ Rectal Pain / Levator Spasm
☐ Dysparunia / Vaginal Pain	☐ Neurogenic Bladder	☐ Urinary / Rectal Fistulas
☐ Enlarged Prostate	☐ Overactive Bladder	☐ Urinary Frequency / Urgency / Urge Incontinence
☐ Fecal Incontinence	☐ Pelvic Organ Prolapse	☐ Urinary Incontinence / Mixed Incontinence / Stress Incontinence
☐ Female Sexual Dysfunction	☐ Pelvic Pain	☐ Vaginal Absence Deformities

☐ Other (Please Specify):

NOTICE: *This list is merely a reference intended to be used as a guideline to assist in identifying the reason for the referral. It is not an all inclusive list and none of the above may apply to your patient.*

PLEASE FAX THIS FORM TO (713) 791-5023

WE WILL CONTACT THE PATIENT THE SAME DAY OR NEXT WORKING DAY

PHYSICIAN'S NAME	PHONE	FAX
PHYSICIAN'S SIGNATURE	**OFFICE CONTACT PERSON**	**DATE/TIME**