REFERRAL FORM

CENTER FOR PEDIATRIC & ADOLESCENT GYNECOLOGY, FERTILITY FLORIDA
Lawrence Amesse, MD, PA
12955 Palms West Drive, Suite 200 •Loxahatchee, FL 33470
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Request Date _____ Nature of Referral: ☐ Urgent ☐ Routine

PATIENT INFORMATION

Patient's Name _____ DOB_____

Patient is ☐ a minor & is in custody of : ☐ Parent ☐ Guardian ☐ Other or ☐ ≥18 YO

Parent or Guardian Name(s)_____

Home phone _____ Work/Cell phone _____

REASON FOR REFERRAL

☐ Abnormal Menses: ☐ *Amenorrhea* ☐ *Heavy Menstrual Bleeding* ☐ *Irregular, Painful Periods*

☐ Adolescent Health & Initial Gyn Visit

☐ Care of Patients w/Developmental Delays

☐ Congenital Anomalies

☐ Contraception

☐ Fertility Preservation: ☐ *Chemotherapy, Radiotherapy*

☐ Labial Adhesions

☐ PCOS

☐ Pelvic Pain ☐ Ovarian Cysts, Mass

☐ Puberty Disorders: ☐*Early* ☐*Delayed*

☐Sexually Transmitted Infections

☐Vulvo-vaginitis

REFERRING PHYSICIAN, PRACTICE NAME

Name_____

Office Contact Person_____

Phone_____Fax _____

Our policy is to contact referrals within 24 hours. If we are unable to contact family within 1 week of the referral, we will notify your office.