azura vascular care

Patient scheduling form

Uterine fibroid embolization (UFE)

Today's Date _____

Patient Name _____ **Date of Birth** _____

Patient Address _____

City _____ **State** _____ **Zip Code** _____

Home # _____ **Office #** _____ **Cell #** _____

Allergies _____

Any anticoagulants? _____

Insurance _____ **Policy #** _____

Referring Physician _____ **Physician Extender** _____

Physician Phone # _____ **Physician Fax #** _____

Diagnosis

O **Uterine Fibroid** O **Menorrhagia** O **Dysmenorrhea** O **Adenomyosis**

O Submucosal O Subserosal

O Intramural O Pedunculated

Information needed - *if available, please send*

Endometrial Biopsy Result **PAP Smear Result** **Imaging Studies**