John Rundback, MD
Kevin Herman, MD

PATIENT REFERRAL INFORMATION

Uterine Fibroid Embolization (UFE)

To be completed by referring physician (please print all information)

PATIENT NAME (first and last): _____

PHONE (home): _____ (mobile): _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

LANGUAGE ACCOMMODATION? ___ YES ___NO Specify: _____

REFERRING PROVIDER: _____ NPI#: _____

PHYSICIAN SIGNATURE: _____ DATE:_____

Diagnosis
please check all that apply

- ☐ Submucosal Fibroids
- ☐ Subserosal Fibroids
- ☐ Intramural Fibroids
- ☐ Pedunculated Fibroids
- ☐ Menorraghia
- ☐ Dysmenorrhea
- ☐ Adenomyosis

Additional Information Needed
if available

- ☐ PAP Smear Results
- ☐ Endometrial Biopsy Results
- ☐ Imaging Studies
- ☐ Anticoagulants? Yes No
- ☐ Allergies? Yes No

IF YES, DESCRIBE:

_____

_____

To refer a patient, please fax completed form to: 973.947.6647

Please include patient demographics, H&P, insurance card, imaging studies, and endometrial biopsy results.

Please make patient aware that she will be contacted by NJ Endovascular & Amputation Prevention to schedule the consultation.

347 Mount Pleasant Avenue, Suite 100, West Orange, NJ 07052
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americanendovascular.com