

Potomac Obstetrics & Gynecology LLC

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Referral Form

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Patient Name: _____

Patient Phone Number: _____

Referring Physician Name: _____

Referring Physician Phone Number: _____

Reason for Consultation

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Gynecologic Problem | <input type="checkbox"/> Positive Home Pregnancy Test | <input type="checkbox"/> Abnormal Pap |
| <input type="checkbox"/> Abnormal Ultrasound | <input type="checkbox"/> Abnormal Lab Result | |

Other: _____