



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

- Uterine Fibroid
- Menorrhagia
- Dysmenorrhea
- Adenomyosis
- Submucosal
- Subserosal
- Intramural
- Pedunculated

Information needed - *if available, please send*

Endometrial Biopsy Result

PAP Smear Result

Imaging Studies