

OB/GYN to PCP Medical Record Update

Consulting Provider Information

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Patient Information

Name: _____

D.O.B.: _____

Date: _____

Patient Care Information

Please indicate if any of the following tests were performed:

	Date:	Result:
<input type="checkbox"/> Mammogram	_____	_____
<input type="checkbox"/> Pap Test	_____	_____
<input type="checkbox"/> Chlamydia Screening	_____	_____
<input type="checkbox"/> Other: _____		

Diagnosis: _____

Follow-up Care: This office PCP Another Physician: _____

Recommendations / Comments: _____

Mail or fax to Primary Care Practitioner at:

Name: _____

Address: _____

Fax Number: _____

Reviewed by PCP (initial): _____