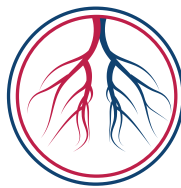

Fishkill
Endovascular Center
Affiliated with American Endovascular

A. Ramsey Abadir, MD • Chris Donikyan, DO • Vivek Patil, 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: 845.896.1990

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

Please make patient aware that she will be contacted by Fishkill Endovascular Center to schedule the consultation.

60 Merritt Boulevard, Suite 107, Fishkill, New York 12524
PHONE: 845.896.1900 | FAX: 845.896.1990 | americanendovascular.com

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