



**Lower Manhattan
Endovascular Center**

Affiliated with American Endovascular

Joseph Shams, 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
- Menorrhagia
- 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: 212.966.2022

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

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

