

## URODYNAMICS STUDY REFERRAL ORDER FORM

### Patient Information

- Patient Name: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_
- Phone Number: \_\_\_\_\_

### Ordering Provider Information

- Provider Name: \_\_\_\_\_
  - Clinic/Facility: \_\_\_\_\_
  - Phone: \_\_\_\_\_
  - Fax: \_\_\_\_\_
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### Clinical Information

- **Primary Diagnosis (ICD-10 Code):** \_\_\_\_\_
  - **Secondary Diagnosis (if applicable):** \_\_\_\_\_
  - **Reason for Study / Clinical Indication:**
    - Urinary Incontinence
    - Urgency / Frequency
    - Urinary Retention
    - Neurogenic Bladder
    - Pelvic Organ Prolapse
    - Other: \_\_\_\_\_
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### Patient Assessment

- **Weight:** \_\_\_\_\_ (lbs/kg)
- **Height:** \_\_\_\_\_
- **Mobility Status:**
  - Independent
  - Requires Assistance
  - Wheelchair

Bedbound

Other: \_\_\_\_\_

• **Cognitive Status (if relevant):**

Alert & Oriented

Impaired

Other: \_\_\_\_\_

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**Current Medications (relevant to bladder function):**

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**Special Considerations / Precautions:**

Requires Hoyer lift

Fall risk

Isolation precautions

Interpreter needed (language): \_\_\_\_\_

Other: \_\_\_\_\_

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**Provider Signature**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Return fax to: Patient Scheduling at 402-421-1945**

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**FOR OFFICE USE ONLY**

• Scheduled Date: \_\_\_\_\_

• Prep Instructions Given:  Yes  No

• Notes: \_\_\_\_\_