UNIVERSITY OF ILLINOIS
Hospital & Health Sciences System
Center for Women's Health

1801 W. Taylor St., Suite 4C, Chicago, IL 60612

(P) 312-413-8681 (F) 312-355-5838

Center for Reproductive Health Referral Form

Jonah Fleisher, MD, MPH
Erica Hinz, MD, MPH

Note: Some payers now require pre-authorization for all procedures.
If records and insurance info are not sent with referral, patient care may be delayed.

Patient Information

Demographic Info:		**Insurance Info:**	
Last Name:	______	Health plan:	______
First Name:	______	Member ID:	______
DOB:	______	Group Name:	______
Phone:	______	Group #:	______
Referring MRN:	______		
UIC MRN:	______		

Referring Provider Information

I am referring the above patient for care at the Center for Reproductive Health.

Name: Signature: Date:

Address: ______

______

Best Way to Contact: ☐ Telephone ☐ Fax ☐ Pager Number:

Clinical Information

Reason for Referral
- ☐ Induced Abortion (reason): ______
- ☐ Miscarriage management
- ☐ IUD lost/malpositioned
- ☐ Nexplanon management
- ☐ Contraceptive consultation: ______

Pregnancy Dating LMP: EDD:

Diagnosis codes (if known) ______

For abortion or miscarriage referrals:

Please include:
- ☐ Prenatal records
- ☐ Dating Ultrasound(s)
- ☐ Relevant Consultants' notes

If the patient has a fetal abnormality, please include:
- ☐ MFM Consult notes and Anatomy Ultrasound(s)
- ☐ Genetic screening results (Quad screen, cfDNA)
- ☐ Genetic diagnostic results (CVS or amniocentesis)

For Contraceptive referrals:

Please include:
- ☐ Relevant clinic notes
- ☐ Procedure notes from attempted device insertion/removals

Please fax this form and all records to: 312-355-5838