for Women
Holistic Gynecology and Conscious Wellness

Consultation Form

Practitioner_____
Phone_____Fax_____
Address_____
This is to introduce _____DOB_____
Purpose
_____Consultation for opinion / recommendation/second opinion only
_____Consultation for evaluation and management of a gynecologic problem
_____Consultation for surgical treatment
_____Take over women's health care needs

Reason for Consult. Indicate the specific clinical question you would like to be addressed including a brief summary of the most relevant clinical information as it relates to your overall care plan , i.e. history, tests, and treatments

Specify Urgency: (Choose one)
_____Urgent: (1-2 days) -for appts that need to be seen in <48 hours please call the office so there can be a direct phone triage call with Dr Motyka)
Minimally provide written justification for urgency
_____Subacute (1-2 weeks)
_____Routine

_____ Core medical Records attached
_____Demographics attached
_____ Pt aware of referral and agrees
_____ Special patient care needs listed

Signature: _____Date_____

Our office will notify you when the patient is scheduled. We will send you a timely response and will communicate directly with the patient/ caregiver with results and plans

Elizabeth G. Motyka, MD
727 Eastowne Drive
Suite 200A
Chapel Hill, NC
27514
Phone 919-401-4515
Fax 919-401-4503

I, _____agree that the practitioners above may share information regarding my healthcare and authorize them to release such information to each other as necessary.
Patient signature: _____Date_____