

# Empowering Women's Wellness

## PATIENT DETAILS

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## REFERRING CLINICIAN

Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## REASON FOR REFERRAL

- |   |   |
|---|---|
| <input type="checkbox"/> Urinary incontinence (stress, urge, mixed) | <input type="checkbox"/> Genitourinary syndrome of menopause                        |
| <input type="checkbox"/> Overactive bladder                         | <input type="checkbox"/> Changes in the aesthetics appearance of the female anatomy |
| <input type="checkbox"/> Sexual dysfunction or painful intercourse  | <input type="checkbox"/> Recurrent vaginal infection                                |
| <input type="checkbox"/> Pelvic floor weakness                      | <input type="checkbox"/> Chronic bladder infection                                  |
|   | <input type="checkbox"/> Others   |



EMPOWERRF  
by INMODE