The Echenberg Institute
for pelvic & sexual pain

Phone: 610-868-0104 Fax: 610-868-0204

IMPORTANT INFORMATION

Your Name: _____ Date: _____

Who referred you to our office: _____

1. Primary Care Physician: _____
2. Gynecologist: _____
3. Counselor/Psychiatrist: _____
4. When was your last full exam: _____
5. When was your last pap smear: _____

Please list all practitioners that you plan on giving a copy of your initial report to. Please provide us with the full name, office address, including zip code and phone number.

_____ _____
_____ _____
_____ _____
_____ _____

_____ _____
_____ _____
_____ _____
_____ _____

If you are referred to another aspect of our program, for example: physical therapy, counseling, nutritionist, other physicians: Do you give permission to send your initial assessment to these practitioners? Yes_____ No_____

Signature: _____
Date: _____