

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

**CHECK OUT SHEET
UROGYNECOLOGY**☐ PT TO SEE SURGERY SCHEDULER TODAY**Follow up time frame:**

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

**CHECK OUT SHEET
UROGYNECOLOGY**☐ PT TO SEE SURGERY SCHEDULER TODAY**Follow up time frame:**

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

**CHECK OUT SHEET
UROGYNECOLOGY**☐ PT TO SEE SURGERY SCHEDULER TODAY**Follow up time frame:**

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

**CHECK OUT SHEET
UROGYNECOLOGY**☐ PT TO SEE SURGERY SCHEDULER TODAY**Follow up time frame:**

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

**CHECK OUT SHEET
UROGYNECOLOGY**☐ PT TO SEE SURGERY SCHEDULER TODAY**Follow up time frame:**

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

**CHECK OUT SHEET
UROGYNECOLOGY**☐ PT TO SEE SURGERY SCHEDULER TODAY**Follow up time frame:**

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

JANET HUDSON

MRN: 519545

DOB: 11/12/1946

MD: DANIELLE TAYLOR

12/06/2023

01:15

Date: 11/16/2023

CHECK OUT SHEET UROGYNECOLOGY

☐ PT TO SEE SURGERY SCHEDULER TODAY

Follow up time frame:

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

CHECK OUT SHEET UROGYNECOLOGY

☐ PT TO SEE SURGERY SCHEDULER TODAY

Follow up time frame:

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

**CHECK OUT SHEET
UROGYNECOLOGY**☐ PT TO SEE SURGERY SCHEDULER TODAY**Follow up time frame:**

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

**CHECK OUT SHEET
UROGYNECOLOGY**☐ PT TO SEE SURGERY SCHEDULER TODAY**Follow up time frame:**

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

SUE S GOFF

MRN: 508379

DOB: 8/6/1949

MD: DANIELLE TAYLOR

12/06/2023

02:30

Date: 11/16/2023

CHECK OUT SHEET UROGYNECOLOGY

☐ **PT TO SEE SURGERY SCHEDULER TODAY**

Follow up time frame:

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

**CHECK OUT SHEET
UROGYNECOLOGY**☐ PT TO SEE SURGERY SCHEDULER TODAY**Follow up time frame:**

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

CHECK OUT SHEET UROGYNECOLOGY

☐ PT TO SEE SURGERY SCHEDULER TODAY

Follow up time frame:

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

<div><div><u>Vitals:</u></div><div><div>BP:</div><div>HR:</div><div>WT:</div><div>HT:</div><div>O2:</div><div>Temp:</div><div>Pain:</div></div></div>	<div><div><u>Urine Collection:</u></div><div><div>Voided Volume (Hat):</div><div>Post Void Residual:</div></div></div>
--	---

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

Date: 11/16/2023

CHECK OUT SHEET UROGYNECOLOGY

☐ PT TO SEE SURGERY SCHEDULER TODAY

Follow up time frame:

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

Date:

Intake Form

Vitals:

BP:

HR:

WT:

HT:

O2:

Temp:

Pain:

Urine Collection:

Voided Volume (Hat):

Post Void Residual:

POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam: _____

VICKIE MOON

MRN: 660023

DOB: 5/22/1963

MD: DANIELLE TAYLOR

12/06/2023

03:30

Date: 11/16/2023

CHECK OUT SHEET UROGYNECOLOGY

☐ PT TO SEE SURGERY SCHEDULER TODAY

Follow up time frame:

PRN	1 WEEK	2 WEEKS	4 WEEKS	6 WEEKS
	2 MONTHS	3 MONTHS	6 MONTHS	1 YEAR

Pelvic Floor Therapy: Doctors Piedmont Aiken

Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

OAB Med Check	PVR check	Urodynamics	Pessary Fitting	Pessary Check
Cystoscopy	Cystoscopy with Botox	Post –operative Visit	Imaging results Discussion	PT Follow up
PTNS	Pelvic Floor Injections	Pelvic floor dysfunction	Prolapse Follow up	Urinary Incontinence follow up
Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____