KATHRYN PEARSON
MRN: 702221
DOB: 1/1/1955
MD: URODYNAMICS

12/06/2023
08:30

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:_____

KATHRYN PEARSON
MRN: 702221
DOB: 1/1/1955
MD: URODYNAMICS

12/06/2023
08:30

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: _____

LINDA J ELLIOTT
MRN: 694555
DOB: 11/27/1944
MD: URODYNAMICS

12/06/2023
10:30

Date:

Intake Form

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Voided Volume (Hat):

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POP-Q

Aa_____	Ba_____	C_____
Pb_____	Gh_____	TVL_____
Ap_____	Bp_____	D_____

Pelvic Floor Strength: _____

Rectal Exam:_____

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MRN: 694555
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12/06/2023
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Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____

CORINA E CANALES
MRN: 694286
DOB: 1/12/1947
MD: URODYNAMICS

12/06/2023
01:00

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:_____

CORINA E CANALES
MRN: 694286
DOB: 1/12/1947
MD: URODYNAMICS

12/06/2023
01:00

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Transvaginal Ultrasound: Doctors Piedmont

Labs Needed: _____

CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

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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: _____

BEVERLY H HADLEY
MRN: 694990
DOB: 1/26/1958
MD: URODYNAMICS

12/06/2023
03:00

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:_____

BEVERLY H HADLEY
MRN: 694990
DOB: 1/26/1958
MD: URODYNAMICS

12/06/2023
03:00

Date: 11/16/2023

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UROGYNECOLOGY

☐ **PT TO SEE SURGERY SCHEDULER TODAY**

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Transvaginal Ultrasound: Doctors Piedmont

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CT Scans: Doctors Piedmont Wheeler**

CT Scans Needed: _____

Outside Referral: _____

Follow up reason:

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Interstitial Cystitis	Microscopic Hematuria	Recurrent UTI	Vaginal atrophy	Chronic pelvic pain

Physician Signature: _____