

Date:

Dear Dr. _____,

Our mutual patient, _____, is interested in the *FemiLift* CO2 laser procedure for vaginal rejuvenation. In order for the patient to move forward with the process, we are requesting additional patient medical history information.

Please free to contact me if you have any questions.

Sincerely,

Nicole Hayre, MD

Please review the following checklist:

Patient has a:

_____ normal pap smear in the last 3 months. Date: ____/____/____

_____ normal pelvic exam in the last 3 months. Date: ____/____/____

Patient ***does not***:

_____ have an active vaginal infection. _____ have a mesh sling.

_____ have a history of HPV. _____ have a uterine prolapse.

Comments:

Practitioner Signature

Date

Printed Name

Please fax this completed form to: 703-827-8638.