



WOMEN'S COLLEGE HOSPITAL
 Healthcare | REVOLUTIONIZED
 76 Grenville Street, Toronto, Ontario M5S 1B2
Access Centre Tel: 416-323-6321
Fax to: 416-323-6330

GYNAECOLOGY PROGRAM REFERRAL FORM

Select Clinic Type:

- Abnormal Uterine Bleeding Clinic
- Colposcopy Clinic
- General Gynaecology Clinic
- Familial Ovarian Cancer Clinic (FOCC)
- Polycystic Ovarian Syndrome Clinic

- Premature Ovarian Insufficiency with Turner's Clinic
- Vulva Dermatology Clinic
- Women's Equity Clinic
- Young Women's Clinic

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ Date of Birth: ____ / ____ / ____
 DD/MM/YYYY
 Health Card: _____ Version Code: _____
 Address: _____
 Telephone: _____ Alternate: _____

Referral Date: ____ / ____ / ____
 DD/MM/YYYY

Specific Physician? No (first available)
 Yes (Dr. _____)

ADDITIONAL PATIENT INFORMATION

Other insurance coverage (IFH, UHIP, other.) Self-pay
 Language spoken: Interpreter required: Yes No

Allergies:

Gender:

REFERRING PROVIDER INFORMATION

Name: _____ Billing number: _____
 Address: _____
 Telephone: _____
 Fax: _____ Signature: _____

Alternate report sent to:
 (name/contact information)

REASON FOR REFERRAL

Diagnosis and/or chief complaint:

Previous management:

CLINICAL INFORMATION /FINDINGS:

Past and current medical history: (Include cumulative patient profile, if available)

Please attach the following:

- ▶ Blood work (i.e. CBC)
- ▶ Pelvic ultrasound/sonohysterography
- ▶ Cervical cytology/pathology
- ▶ Endometrial biopsy results
- ▶ Operating Room record/summary
- ▶ Consults
- ▶ Medical history

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