



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 | Polycystic Ovarian Syndrome Clinic |
| Bone Marrow Transplant: Graft versus Host Disease or POI | Premature Ovarian Insufficiency(POI) with Turner's Clinic |
| Colposcopy Clinic | Vulva Dermatology Clinic |
| General Gynaecology Clinic | Women's Equity Clinic |
| Familial Ovarian Cancer Clinic (FOCC) | 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: ____ / ____ / ____ **Specific Physician?** No (first available)
 DD/MM/YYYY Yes (Dr. _____)

ADDITIONAL PATIENT INFORMATION

Name in use: _____
 Gender Identity: _____ Pronouns: He/Him She/Her They/Them Other: _____
 Other insurance coverage (IFH, UHIP, other.) _____ Self-pay
 Language spoken: _____ Interpreter required: Yes No
 Allergies: _____

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:

<p>Past and current medical history: (Include cumulative patient profile, if available)</p>	<p>Please attach the following:</p> <ul style="list-style-type: none"> ▶ 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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