WCHI
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

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ Date of Birth: ____/____/____
DD/MM/YYYY

Health Card: _____ Version Code: _____

Address: _____

Telephone: _____ Alternate: _____

Select Clinic Type:

- ☐ Abnormal Uterine Bleeding Clinic
- ☐ Bone Marrow Transplant: Graft versus Host Disease or POI
- ☐ Colposcopy Clinic
- ☐ General Gynaecology Clinic
- ☐ Familial Ovarian Cancer Clinic (FOCC)
- ☐ Polycystic Ovarian Syndrome Clinic
- ☐ Premature Ovarian Insufficiency(POI) with Turner's Clinic
- ☐ Vulva Dermatology Clinic
- ☐ Women's Equity Clinic
- ☐ Young Women's Clinic

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

Specific Physician? ❑ No (first available) ❑ 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:

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