WCH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
M5S 1B2

Tel: 416-351-3700 Fax: 416-323-6319

BAY CENTRE FOR BIRTH CONTROL REFERRAL FORM

REFERRAL DATE: ____/____/_____
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:_____ HCN:_____

Name:_____

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

Address:_____

Telephone:_____

Please note: We accept patients by self-referral as well as referral by a Health Care Provider.

ADDITIONAL PATIENT INFORMATION

Preferred name: WCH Medical Record Number (*if known*):

Gender: Pronouns: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Other: _____

Other insurance coverage (IFH, UHIP, etc.): ❑ Self-pay

Language spoken: Interpreter required: ❑ Yes ❑ No

Allergies:

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: _____

Signature: _____

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: _____
Primary Care Provider Telephone #: _____

REASON FOR REFERRAL

☐ Intrauterine Device (IUD) Insertion
☐ Intrauterine Device (IUD) Removal
☐ Termination of Pregnancy
☐ Other: _____
☐ Implant Insertion
☐ Implant Removal
☐ Pap Test
☐ Sexually Transmitted Infections (STIs) Testing/Treatment
☐ Contraception Counselling
☐ Emergency Contraception

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, beta hCG)
► Ultrasound
► Test results (i.e. Pap Test, STI screening)
► Medical history