



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

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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: _____	Billing #: _____
Address: _____	
Telephone: _____	Signature: _____
Fax: _____	

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

REASON FOR REFERRAL

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

Diagnosis and/or chief complaint:

Previous management:

CLINICAL INFORMATION / FINDINGS:

Past and current medical history: <i>(Include cumulative patient profile, if available)</i> 	Please attach the following: <ul style="list-style-type: none"> ▶ Blood work (i.e. CBC, beta hCG) ▶ Ultrasound ▶ Test results (i.e. Pap Test, STI screening) ▶ Medical history
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