BAY CENTRE FOR BIRTH CONTROL
REFERRAL FORM

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:
(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

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