GYNECOLOGY REFERRAL FORM

URGENCY:  □ Routine  □ Semi-Urgent  □ Urgent
REFERRAL DATE:  /  /  

SPECIFY PHYSICIAN:  □ No (First available)  □ Yes (Dr.______) 

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:

□ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: ____________________________
Primary Care Provider Telephone: _______________________

REASON FOR REFERRAL

Clinic Type:  □ Colposcopy  □ Complex contraception  □ Template ovary syndrome  □ Premature ovarian insufficiency/Turner Syndrome  □ Specialized gynecology  □ Vulva dermatology  □ Women’s equity  □ Other: ____________________________

Previous management:

ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Current medications (include list):

Please attach all relevant results/reports:
□ Bloodwork  □ Pelvic ultrasound/Sonohysterography  □ Cervical cytology/Pathology  □ Endometrial biopsy  □ Operating Room record/Summary  □ Consultation reports

Fax Disclaimer: This fax transmission contains confidential information that is intended only for the Women’s College Hospital Clinics. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of the contents of this fax is strictly prohibited. If you have received this fax transmission in error, please immediately notify the referring health practitioner at the telephone number provided above to arrange for the return or destruction of this document.