WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
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HERNIA SURGERY 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:_______________ Alternate #:______________

ADDITIONAL PATIENT INFORMATION

Preferred name: Gender (*if not same as above*):

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ ____________________

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

Language spoken: Interpreter required: ☐ Yes ☐ No

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

☐ Inguinal hernia:____
☐ Umbilical hernia:____
☐ Epigastric hernia (above umbilicus):____
☐ Other hernia:____

ADDITIONAL CLINICAL INFORMATION

Has the patient had hernia surgery before?
☐ No ☐ Yes *(surgery name and date)*:____

Is the patient taking anticoagulants
☐ No ☐ Yes *(medication name and dosage)*:_____________________________________

Height (cm):____________ **Weight (kg):**____________

ADDITIONAL CLINICAL INFORMATION

Past medical/surgical history: ***(diagnostic imaging is not necessary)***

Allergies and reaction:

Current medications (include list):

PERMISSION TO CONTACT

By providing the patient's email address, you are confirming that the patient has consented to receiving email communications from WCH regarding their appointment(s), patient experience surveys, enrollment in our patient portal (myHealthRecord), and other medical documentation.

Patient email address:____

Disclaimer: All electronic communication carries some risk. Patients may withdraw their consent to receive emails from WCH or change their preferences at any time.

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