REFERRAL FORM

Please fax form to: 204-958-6730
Phone: 204-958-6777

Referring Physician Information: *OR Physician Stamp*

Referring Physician/Nurse Practitioner:

Prac ID #:

Phone:

Fax:

Patient Information: *Affix patient label*

Name: Telephone:

Health card #: DOB:

Address:

Please indicate reason for referral:

▫ Perimenopause/Menopausal disorders

▫ IUD Insertion OR ▫ IUD Removal

▫ Emergency Contraception (*patients will be booked within 24hrs*)

▫ STI testing/counselling

▫ Other:

▫ Contraception

▫ Endometrial biopsy

▫ Routine Paps/Breast Exams

Please attach any relevant investigations including Pelvic U/S reports, Paps tests, mammogram results, labs and consults from relevant clinicians etc. For other urgent referrals, please phone our office.

The patient will be contacted directly from our office to confirm an appointment date and time within 1 week.

Please note a missed appointment fee of $100 will apply for all no shows and last minute cancellations with less than 48 business hours notice.