MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Frances Bloomberg Centre for Women's and Infants' Health

Women's Unit
700 University Ave., 8th Floor South
Toronto, ON M5G 1Z5
Phone: (416) 586-4800 ext. 4621 Fax: (416) 586-5941

Referral Form

Premature Ovarian Insufficiency Program

Please complete ALL of the following information and fax to 416-586-5941. We will contact your office with the appointment after all required information is completed.

Patient Information

Name: _____ Phone:_____
Last Name *First Name*

Date of Birth: _____ Health Card No._____
(YYYY-MM-DD)

Does patient need a translator? ❑ No ❑ Yes If yes, specify language _____

Does patient have any special needs? ❑ No ❑ Yes If yes, specify _____

Is patient taking hormone replacement? ❑ No ❑ Yes If yes, specify _____

Is patient taking any other medications? ❑ No ❑ Yes If yes, specify _____

_____

Relevant medical history:

Investigations/Care to-date (please indicate what has been done and attach results to referral)

Pelvic Ultrasound? ❑ No ❑ Yes Estradiol Level ❑ No ❑ Yes Bone Density Scan ❑ No ❑ Yes

Chromosomes ❑ No ❑ Yes FSH ❑ No ❑ Yes

Lab Results (e.g. CBC, Electrolytes, Glucose, Lipids, TSH, EKG, Echo, any antibody studies) ❑ No ❑ Yes

Please attach copies of all diagnostic tests and lab results with this referral and fax to 416-586-5941.

Referring Physician

Name: _____ Phone:_____
Last Name *First Name*

Address:_____ Fax: _____

Email:_____ OHIP Billing No. _____

Premature Ovarian Insufficiency Program Use Only

Referral Accepted: ❑ No ❑ Yes Appointment Date/Time: _____