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

Menopause Clinic

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 _____

Previous referral to menopause clinic? ❑ No ❑ Yes If yes, specify year(s) _____

Previous use of hormone replacement? ❑ No ❑ Yes If yes, please list _____

_____

Patient is: Menopausal (date of last menstrual period) _____ or ❑ Perimenopausal
(YYYY-MM-DD)

Main reason for referral: ❑ Vasomotor symptom management ❑ Problem with current HRT

Medications

Specific Concerns

Explain:

To process this referral, the following documentation is required:

- ❑ Bone Mineral Density
- ❑ Mammogram
- ❑ Pap Smear
- ❑ Bloodwork
- ❑ Pelvic Ultrasound
- ❑ Reports from other specialists involved in patient's care
- ❑ Other lab tests pertinent for referral

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. _____

Please inform your patient that we offer Menopause Information Sessions. Registration is required and may be completed online at www.bookking.ca/bkmtsinaipub/courses/index.asp or they may call 416-586-4800, ext. 2307

Menopause Clinic Use Only

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