



WOMEN'S COLLEGE HOSPITAL

Healthcare | REVOLUTIONIZED

76 Grenville Street, Toronto, Ontario M5S 1B2

Gynaecology Clinic Tel: 416-323-7744

Fax to: 416-323-6330

GYNAECOLOGY PROGRAM REFERRAL FORM

Select Clinic Type:

- Abnormal Uterine Bleeding Clinic
- Bone Marrow Transplant: Graft versus Host Disease or POI
- Colposcopy Clinic
- Specialized Gynaecology Clinic
- Familial Ovarian Cancer Clinic (FOCC)
- Polycystic Ovarian Syndrome Clinic
- Premature Ovarian Insufficiency(POI) with Turner's Clinic
- Vulva Dermatology Clinic
- Women's Equity Clinic

PATIENT INFORMATION

(Affix Patient Label/Identification Here)

Name: _____ Date of Birth: ____ / ____ / ____

DD/MM/YYYY

Health Card: _____ Version Code: _____

Address: _____

Telephone: _____ Alternate: _____

Referral Date: ____ / ____ / ____
DD/MM/YYYY

Specific Physician? No (first available)
 Yes (Dr. _____)

ADDITIONAL PATIENT INFORMATION

Name in use:

Gender Identity: _____ Pronouns: He/Him She/Her They/Them Other: _____

Other insurance coverage (IFH, UHIP, other.) _____ Self-pay

Language spoken: _____ Interpreter required: Yes No

Allergies:

REFERRING PROVIDER INFORMATION

Name: _____ Billing number: _____

Address:

Telephone:

Fax: _____ Signature: _____

Alternate report sent to:
(name/contact information)

REASON FOR REFERRAL

Diagnosis and/or chief complaint:

Previous management:

CLINICAL INFORMATION /FINDINGS

Past and current medical history:
(Include cumulative patient profile, if available)

Please attach the following:

- ▶ Blood work (i.e. CBC)
- ▶ Pelvic ultrasound/sonohysterography
- ▶ Cervical cytology/pathology
- ▶ Endometrial biopsy results
- ▶ Operating Room record/summary
- ▶ Consults
- ▶ Medical history

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