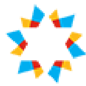

Sinai Health | Mount Sinai Hospital
Joseph and Wolf Lebovic Health Complex
Frances Bloomberg Centre for Women's and Infants' Health

Women's Unit
700 University Ave., 8th Floor South
Toronto, ON M5G 1Z5
Phone: (416) 586-4800 ext. 4621 Fax: (416) 586-5941
Clinic Hours: Monday-Friday 8:00 am - 4:00 pm
Weekends - CLOSED

Referral Form

Date: _______________

Menopause Clinic

The Women's Unit will contact your patient with an appointment after all required information is completed.

Patient Information

Name: ______________________________ Phone: ____________________
Last Name *First Name*

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

Address: ____

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:

<u>To process this referral, the following documentation is required</u>:

- ❑ 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 complete all of the following information and attach copies of ALL diagnostic tests and lab results with this referral and fax to 416-586-5941. Incomplete referrals will be returned for more info.

Referring Physician

Name: ______________________________ Phone: ____________________

Address: ______________________________ Fax: ____________________

Email: ______________________________ OHIP Billing No. ____________________

Menopause Clinic Use Only

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

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