Halton Fertility
& WOMEN'S HEALTH CENTRE

**GYNECOLOGY REFERRAL FORM**
FAX COMPLETED FORM TO:
289-891-9591

## PATIENT INFORMATION

Apply patient sticker or fill the following:
Last name _____ First name _____
Date of birth (DD/MM/YYYY) _____
Health card number _____
Telephone _____ Alternate number _____

## REFERRING PHYSICIAN

Physician Name _____
Telephone _____ Fax _____
OHIP billing number : _____ CPSO license number : _____

## REASON FOR REFERRAL

**Gynecology**

- ☐ Annual health evaluation
- ☐ Pap smear, Cervical cancer screening
- ☐ Colposcopy
- ☐ Contraception management
- ☐ IUD insertion/removal
- ☐ Endometrial biopsy
- ☐ Menopause management
- ☐ Abnormal uterine bleeding
- ☐ Fibroids/polyps
- ☐ Menstruation dysfunction / amenorrhea
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Sonohysterograms (evaluation of uterine cavity and tubal patency)
- ☐ Genital prolapse/urinary incontinence
- ☐ Ovarian cyst/tumour
- ☐ Infection / STDs
- ☐ Pelvic pain / endometriosis / dysmenorrhea
- ☐ Genital malformation
- ☐ Vulvar/vaginal cyst/tumour
- ☐ Other_____

*Please attach all relevant test results and consultation reports.*

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