CMC | CORNERSTONE MEDICAL CLINIC

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# WOMEN'S HEALTH REFERRAL FORM

## PATIENT INFORMATION

Surname: _____ First Name: _____

Birthdate: ___/___/_____ (DD/MM/YYYY) PHN: _____

Address: _____ Phone: _____

_____ Alt Phone: _____

## REFERRING PRACTITIONER INFORMATION

☐ Family Doctor Referring Practitioner: _____

☐ Specialist Clinic: _____

☐ Nurse Address: _____

☐ Other: _____ Phone: _____ Fax: _____

**REFERRAL TO:**

☐ Next available physician

☐ Specific physician: _____

**URGENCY OF REFERRAL**: ___ URGENT ___ ROUTINE

**REASON FOR REFERRAL**: (please include copies of all relevant imaging, labs, consults)

☐ pap smear only

☐ low risk maternity care EDC: ____/____/_____ (DD/MM/YYYY) *

☐ contraceptive or sexual health counselling

☐ IUD consult/insertion

☐ emergency contraception

☐ endometrial biopsy

☐ breastfeeding medicine

☐ other gynecologic concern (attach referral letter) _____

*Low risk maternity care patients must meet the following requirements:
Age <42 years; pre-pregnancy BMI <40; singleton pregnancy; no major uterine abnormality; no major fetal abnormality; no major pre-existing maternal medical condition; no history of preterm birth prior to 35 weeks gestation; no history of severe pre-eclampsia or HELLP; if interested in a trial of labor after cesarean, only one prior lower segment cesarean with an inter-delivery interval of at least 18 months.

Practitioner Signature: _____ Date: ___/___/_____(DD/MM/YYYY)

For more information, please visit our website at www.cornerstonemedical.ca