CORNERSTONE MEDICAL CLINIC

#100-415 Wellman Crescent
Saskatoon, SK, S7T 0J1
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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/gynecologic examination

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

☐ contraceptive or sexual health counselling

☐ IUD consult/insertion

☐ emergency contraception

☐ urinary incontinence/pelvic floor concerns/pessary fitting (Dr. Conly)

☐ endometrial biopsy

☐ menopause health

☐ breastfeeding medicine (Dr. Emily Sullivan, Dr. Jennifer Wood)

*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