SAFER SIX HAMILTON
www.safersix.ca

REFERRAL FORM

Please fax all referrals to:

647-417-7044

hamilton@safersix.ca

Inclusive Health in Downtown Hamilton

www.safersix.ca

Patient's Name: _____
Preferred Name: _____
Date of Birth: _____
Health Card #: _____
E-mail Address: _____
Phone: _____
Address: _____

_____

Is patient rostered to FHO? ☐YES ☐NO

(Patients for gender affirming care will need to be derostered for ongoing care with us)

Date: _____

Referring Physician/NP: _____
Billing Number: _____
Phone: _____
Fax: _____
Signature: _____

REASON FOR REFERRAL:

o Contraception / Birth Control Counselling
o Doxy PEP Medication
o Gender Affirming Care - Hormone NEW START (age 17+)
o Gender Affirming Care - Hormone Maintenance (has already been on HRT, age 17+)
o Gender Affirming Care - Surgical Assessment ___ **First Assessment** ___ **Second Assessment**
(If referring for second assessment, please send detailed patient notes and first assessment form with referral)
Patient's desired procedure: _____

o Genital Warts Treatment (Cryotherapy) ___ First Treatment ___ Follow Up Treatment
o HIV Pre-Exposure Prophylaxis (PrEP)
o HPV Screening/Pap Test Last Pap Test: _____. If previous abnormal(s), please fax results.
o IUD Consultation (patient will return on a different day for insertion after consult)
o IUD Insertion (patient has been **already counselled & consent taken, has IUD Rx & pain Rx given/discussed)**
o IUD Removal (this option is only for removal of IUD, not a replacement).
If removal has already been attempted but unsuccessful, please forward details and copy of pelvic ultrasound
o IUD Replacement (Removal & Insertion) - Please make sure patient brings device to appointment
o Medical Abortion (up to 11 weeks gestation) LMP: _____
o Nexplanon Consultation (patient will return on a different day for insertion)
o Nexplanon Insertion (patient has been **already counselled & consent taken, has Nexplanon Rx)**
o Nexplanon Removal (if Nexplanon not palpable or visible, please advise)
o STI Testing (including oral/rectal/vaginal swabs as indicated)
o STI Treatment __ Chlamydia __ Gonorrhea __ Syphilis __ Other :
o Sexual health Vaccinations __ Hep A __ Hep B __ HPV __ MPOX __Other:

Please send patient's CPP with referral. We will return any incomplete referral forms which will result in delay.
Thank you for your referral and we will contact patient directly with appointment details when available.
For physicians within a FHO/FHT, please note that in-basket procedure codes may result in negation to rostered patient.