SAFER SIX

Toronto's Inclusive Health Clinic

SEXUAL HEALTH | MENTAL HEALTH | PHYSICAL HEALTH

www.safersix.ca

REFERRAL FORM

Please fax all referrals to:

647-417-7044

VIRTUAL GYNECOLOGY REFERRAL

Date: _____

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

Is patient rostered to FHO? ☐ YES ☐ NO

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

*Please make sure your name, billing # and information is legible. Otherwise, referrals may be returned to you.

REASON FOR REFERRAL:

- o Abnormal Uterine Bleeding / Irregular Period Management
- o Complex Contraception / Birth Control **(multiple medical comorbidities, etc)**
- o Difficulty conceiving/getting pregnant
- o IUD Consultation (consultation re: Copper or Hormonal IUD)
- o Nexplanon Consultation
- o Medical Abortion LMP: _____
- o Painful periods / Dysmenorrhea
- o PCOS / PMOS
- o Pelvic Pain
- o Premenstrual Dysphoric Disorder (PMDD)

Current Medications:

Current Known Drug Allergies:

Past Medical History:

Past Surgical History:

Previous Pregnancy History:

Other information relevant:

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.