

SAFER SIX

Toronto's Inclusive Health Clinic

SEXUAL HEALTH | MENTAL HEALTH | PHYSICAL HEALTH

REFERRAL FORM

Please fax all referrals to:

647-417-7044

www.safersex.ca

- 27 Roncesvalles Avenue (Parkdale), Toronto
- 26 Dalhousie Street (Downtown), Toronto
- No Preference (Next Available)

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: _____

Requested Physician:

- | | |
|--|---|
| <input type="checkbox"/> Next Available | <input type="checkbox"/> Dr. Chalani Ranasinghe |
| <input type="checkbox"/> Dr Andrew Bennett | <input type="checkbox"/> Dr. Lydia Reynolds-Royer |
| <input type="checkbox"/> Dr. Natalie Blysiuk | <input type="checkbox"/> Dr. Michelle Roseman |
| <input type="checkbox"/> Dr. Mark Cornett | <input type="checkbox"/> Dr. Daseul Shin |
| <input type="checkbox"/> Dr. Sara Pentlicky, GYN | |

REASON FOR REFERRAL:

o Abnormal Uterine Bleeding / Irregular Period Management

o Anoscopy Reason for Anoscopy _____

o Complex Contraception / Birth Control (multiple medical comorbidities, etc)

o Gender Affirming Care - Hormone Start/Maintenance (age 18+)

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 / Insertion (patient will return on a different day for insertion after consult)

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 10 weeks gestation) LMP: _____

o Nexplanon Consultation / Insertion (patient will return on a different day for insertion)

o Nexplanon Removal (if Nexplanon not palpable or visible, please advise)

o PCOS (Polycystic Ovarian Syndrome)

o STI Testing (including oral/rectal/vaginal swabs as indicated)

o STI Treatment __ Chlamydia __ Gonorrhea __ Syphilis __ 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.