MAPLE
WOMEN'S HEALTH

Patient Referral Form

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www.maplewomenshealth.com

Please fax referral form to 437-294-5443

Patient Information:

Patient name:	**Health card number and version code:**
Date of birth:	**Phone:**
Address:	**Email:**

Preferred location: ☐ Markham location ☐ Kingston location ☐ First available location

Reason for referral (please check all boxes that apply):

- ☐ HPV cervical cancer screening / Pap test
- ☐ IUD counselling and insertion
- ☐ IUD removal
- ☐ Implant (Nexplanon) counselling and insertion
- ☐ Implant (Nexplanon) removal
- ☐ Irregular menstrual periods including PCOS
- ☐ Menorrhagia/dysmenorrhea
- ☐ Post menopausal bleeding (including endometrial biopsies)
- ☐ Peri/Menopausal symptoms
- ☐ Vulvodynia and dyspareunia
- ☐ Contraception counselling
- ☐ Medical termination of pregnancy (up to 9 weeks)
- ☐ Early prenatal care (up to 12 weeks)
- ☐ Other: _____

Clinical information (clinical history, medications, allergies and other information that would be helpful to us):

Please attach relevant blood work, ultrasound and any other labs.

Note: We do **not** see patients for suspicious ovarian cysts, endometrial polyps, colposcopy and fertility assessments.

Referring doctor information (include contact information, OHIP number):

Doctor's name:	**Phone:**
OHIP no.:	**Fax:**

☐ **Check here if FHO/FHT to avoid negation**