ST. MICHAEL'S
UNITY HEALTH TORONTO

COLPOSCOPY/VULVA REFERRAL FORM

St. Michael's Health Centre
61 Queen Street East, 5th floor
Toronto, ON M5C 2T2
T: 416-867-7480 | F: 416-867-7478

7 3 8 6 1

Referral Date:	
Last Name:	First Name:
Birth Date:	SMH MRN (J#):
Primary Phone No.: ( )	Cell #: ( )
OHIP No.:	☐ Patient Requires Hoyer Lift - **note max weight 400 lbs**

COLPOSCOPISTS

☐ 1ST Available ☐ Dr. S. Im ☐ Dr. E. Mocarski ☐ Dr. D. Robertson ☐ Dr. A. Simpson
☐ Dr. C. McCaffrey ☐ Dr. A. Nensi ☐ Dr. E. Shore ☐ Dr. M. Yudin

COLPOSCOPY INDICATIONS:

☐ AGC AIS (1 occurrence) ☐ HPV 16, 18, 45 ☐ HPV-O ASCH, HSIL ☐ HPV-O X2 2yrs apart ☐ Unsatisfactory PAP x2	☐ Post-coital bleeding (1 pap result plus HPV results) ☐ Suspicious for malignancy on (circle): Cervix / Vulva / Vagina / Imaging ☐ Post-coital bleeding HPV positive

☐ Other (describe)

Please ensure results are included with the referral, otherwise there will be delays in triaging
The Colposcopy clinic **will call the patient** with an appointment date/time and location if the referral is accepted
FOR YOUR REFERENCE, COLPOSCOPY SCREENING INFORMATION IS AVAILABLE AT: ONTARIOHEALTH.CA/HPVHUB

VULVA SPECIALISTS

☐ 1ST Available ☐ Dr. S. Gold ☐ Dr. E. Mocarski ☐ Dr. A. Nensi ☐ Dr. D. Robertson ☐ Dr. E. Shore

REASON FOR REFERRAL TO VULVA:

☐ Vulvar pain	☐ Vulvar skin changes
☐ Suspected Lichen Sclerosus/Planus	☐ Dyspareunia

☐ Other (describe)

REFERRING PHYSICIAN

Referring Physician/Address (print):	Telephone:	
OHIP Billing #:	Fax:	Signature

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