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:	
Patient Demographics:	
Last Name:	First Name:
Birth Date:	SMH MRN (J#):
Primary Phone No.: ( )	Alternate Phone No.: ( )
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. M. Yudin
☐ Dr. M. Christakis ☐ Dr. C. McCaffrey ☐ Dr. A. Nensi ☐ Dr. E. Shore ☐ Dr. W. Steinberg

REASON FOR REFERRAL TO COLPOSCOPY:

☐ LSIL ASCUS (2 occurrences – fax both)	☐ Post-coital bleeding (1 pap result)
☐ HSIL ASC-H AGC AIS (1 occurrence)	☐ Suspicious lesion for cancer or dysplasia on (circle): Cervix / Vulva / Vagina / Imaging
☐ Vulvar Disorders (condylomas, lichen sclerosus, atypical areas)	☐ Other (describe)

Fax referral with patient's results to the Colposcopy Clinic
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: WWW.CANCERCARE.ON.CA/SCREENFORLIFE

VULVA SPECIALISTS

☐ 1ST Available

REASON FOR REFERRAL TO VULVA:

☐ Vulvar pain	
☐ Vulvar itch	☐ Vulvar skin changes
☐ Dyspareunia	☐ Other (describe)

REFERRING PHYSICIAN

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

TO BE COMPLETED BY COLPOSCOPY CLINIC STAFF

Urgency:	☐ within 2 weeks	☐ 4 weeks	☐ 12 weeks	☐ next available
Appointment with Dr:		Date:		Time:
☐ Please refax referral with relevant pap results or criteria		☐ Referral does not meet current criteria as per CCO guidelines:		
VULVA ONLY: ☐ Vulva 1 (pain or complex patient) ☐ Vulva 2 (any colposcopist/vulvar expert)				
Referral Triage Physician: Dr:			Date:	

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