ST. MICHAEL'S
UNITY HEALTH TORONTO

WOMEN'S HEALTH CENTRE 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 2

Save Reset

Referral Date:	
Patient Demographics:	
Last Name:	First Name:
Birth Date:	SMH MRN (J#):
Home Address:	
Patient Email:	Patient Requires Interpreter:
Primary Phone No.:	Alternate Phone No.:
OHIP No.:	☐ Patient Requires Hoyer Lift – **note max weight 400 lbs.**
GENERAL GYNECOLOGY (ENSURE APPROPRIATE DIAGNOSTIC TESTS ARE ATTACHED)	
Dr. F. Meffe	Dr. S. Mathur
Dr. R. Shah	Dr. C. McCaffrey
Dr. M. Yudin	Dr. D. Robertson
Dr. S. Kives	Dr. A. Simpson
Dr. E. Shore	Dr. A. Nensi
Dr. S. Im	Dr. S. Im's fax number: (416) 977-5572
Dr. W. Steinberg	Dr. W. Steinberg's fax number: (416) 864-5795
UROGYNECOLOGY	
Dr. D. Soroka	**VULVAR CONCERN:** Refer to vulva Clinic (Fax: 416-867-7478)
PRENATAL CARE: Refer to prenatal clinic (Fax: 416-867-3742)	**ABNORMAL PAP:** Refer to colposcopy clinic (Fax: 416-867-7478)
Grade 1 Endometrial Cancer: Refer to the TEAM clinic (Fax: 416-867-7478)	**High BMI Patients with Atypical Endometrial Hyperplasia:** Refer to the TEAM clinic (Fax: 416-867-7478)
Reason for History	

INDICATE ATTACHED RESULTS (REFERRAL WILL NOT CONSIDERED WITHOUT APPROPRIATE REPORTS)		
☐ Diagnostic Imaging	☐ Pap smear	☐ Culture results
☐ Biopsy results	☐ Notes (consults, OR, consent, etc.)	

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

TO BE COMPLETED BY WOMEN'S HEALTH CENTRE STAFF				
Urgency:	☐ Within 2 weeks	☐ 2 – 4 weeks	☐ 4 - 12 weeks	☐ Next available
Appointment Booked with Dr:			**Date:**	**Time:**
Not my area of expertise				
Referral Triage Physician: Dr:			Date:	