



Referral Date:			
Patient Demographics:			
Last Name:		First Name:	
Birth Date:		SMH MRN (J#):	
Primary Phone No.: ()		Alternate Phone No.: ()	
OHIP No.:			
GENERAL GYNECOLOGY (ENSURE APPROPRIATE DIAGNOSTIC TESTS ARE ATTACHED)			
<input type="checkbox"/> Dr. A. Nensi <input type="checkbox"/> Dr. S. Kives <input type="checkbox"/> Dr. A. Simpson <input type="checkbox"/> Dr. M. Christakis <input type="checkbox"/> Dr. E. Shore <input type="checkbox"/> Dr. S. Im (Fax: 416-977-5572)			
<input type="checkbox"/> Dr. F. Meffe <input type="checkbox"/> Dr. D. Robertson <input type="checkbox"/> Dr. R. Shah <input type="checkbox"/> Dr. M. Yudin <input type="checkbox"/> Dr. C. McCaffrey			
<input type="checkbox"/> Chief Resident (ER referrals only) <input type="checkbox"/> Dr. D. Steele/ (Fax: 416-864-5144) <input type="checkbox"/> Dr. W. Steinberg (Fax: 416-864-5795)			
UROGYNECOLOGY (Include urine R&M and C&S results)		MENOPAUSE CLINIC	
<input type="checkbox"/> Dr. D. Soroka		<input type="checkbox"/> Dr. M. Christakis	
Reason for Referral			Relevant History
INDICATE ATTACHED RESULTS (REFERRAL WILL NOT CONSIDERED WITHOUT APPROPRIATE REPORTS)			
<input type="checkbox"/> Diagnostic Imaging		<input type="checkbox"/> Pap smear	<input type="checkbox"/> Culture results
<input type="checkbox"/> Biopsy results		<input type="checkbox"/> Notes (consults, OR, consent, etc.)	
REFERRING PHYSICIAN			
Referring Physician/Address (print):		Telephone:	OHIP #
Signature		Fax:	
TO BE COMPLETED BY WOMEN'S HEALTH CENTRE STAFF			
Urgency:	<input type="checkbox"/> Within 2 weeks	<input type="checkbox"/> 2 – 4 weeks	<input type="checkbox"/> 4 - 12 weeks
			<input type="checkbox"/> Next available
Appointment Booked with Dr:		Date:	Time:
Not my area of expertise			
Referral Triage Physician: Dr:			Date:

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