

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

Referral Date:							
Patient Demographics:							
Last Name:			First Name:	First Name:			
Birth Date:			SMH MRN (J	SMH MRN (J#):			
Home Address:							
Patient Email:			Patient Requ	Patient Requires Interpreter:			
Primary Phone No.:			Alternate Pho	Alternate Phone No.:			
OHIP No.:			Patient Re	Patient Requires Hoyer Lift – note max weight 400 lbs.			
GENERAL GYNECOLOGY (ENSURE APPROPRIATE DIAGNOSTIC TESTS ARE ATTACHED)							
Dr. F. Meffe			Dr. S. Mathur	Dr. S. Mathur			
Dr. R. Shah			Dr. C. McCaf	Dr. C. McCaffrey			
Dr. M. Yudin			Dr. D. Robert	Dr. D. Robertson			
Dr. S. Kives			Dr. A. Simpso	Dr. A. Simpson			
Dr. E. Shore			Dr. A. Nensi	Dr. A. Nensi			
Dr. S. Im			Dr. S. Im's fax	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:				ABNORMAL PAP: Pefer to college apply clinic (Fey: 416, 967, 7479)			
Refer to prenatal clinic (Fax: 416-867-3742) Grade 1 Endometrial Cancer:				Refer to colposcopy clinic (Fax: 416-867-7478) High BMI Patients with Atypical Endometrial Hyperplasia:			
Refer to the TEAM clinic (Fax: 416-867-7478)				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):			Telephone:		OHIP#		
Signature Fax:			Fax:				
TO BE COMPLETED BY WOMEN'S HEALTH CENTRE STAFF							
Urgency: ☐ Within 2	- 4 weeks	☐ 4 - 12 wee	ks	☐ Next available			
Appointment Booked with Dr:				Date:		Time:	
Not my area of expertise							
Referral Triage Physician: Dr:					Date:		

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