WOMEN'S HEALTH CLINIC

1880 Eglinton Ave E #152 Scarborough, ON
Tel: 416-285-7575 Fax: 416-285-7574

PRIMACY Walk-In Clinic
Golden Mile Walk-In & Children's Clinic

PATIENT INFORMATION

Patient's Name: _____ Health Card Number: _____
Date of Birth: _____ Sex: _____ Phone Number: _____
Address: _____
Translation Required: Yes No Language Spoken: _____
Relevant PMHx: _____ CPP Attached
Medications: _____ Allergies: _____

REFERRING PROVIDER INFORMATION

Referring Physician/NP: _____ Billing Number: _____
Fax: _____ Phone: _____ Signature: _____

REASON FOR REFERRAL

Pap Test – *PLEASE ATTACH COPY OF LAST PAP TEST RESULT, IF AVAILABLE*

- ☐ Routine (every 3 years) – Age 25+ years
- ☐ Follow up abnormal – Last Pap Result: _____ Date: _____

Birth Control

- ☐ Contraception Counselling
- ☐ IUD Consult and Insertion – 2 separate appointments
- ☐ IUD Insertion only – By selecting this option, you indicate the patient has already been appropriately counselled and will bring the IUD with them to the appointment
  Type of IUD: _____ (for copper IUDs, please prescribe Mona Lisa V Standard Copper IUD)
- ☐ IUD Removal
- ☐ Nexplanon Consult and Insertion – 2 separate appointments
- ☐ Nexplanon Insertion only – By selecting this option, you indicate the patient has already been appropriately counselled and will bring the Nexplanon with them to the appointment
- ☐ Nexplanon Removal

Sexual Health – *PLEASE NOTE WE DO NOT TREAT HIV INFECTIONS*

- ☐ STI assessment (all genders)
- ☐ STI management of positive result: _____

Other – PLEASE NOTE: WE **DO NOT** ACCEPT REFERRALS FOR CHRONIC PELVIC PAIN, ENDOMETRIOSIS, ABNORMAL UTERINE BLEEDING, PELVIC ORGAN PROLAPSE, PESSARY FITTING
Details: _____

PLEASE FAX ALL REFERRALS TO: **416-285-7574**
WE WILL CONTACT PATIENTS DIRECTLY WITH THEIR APPOINTMENT DETAILS