Oakbay Women's Health Referral Form

<u>Patient information</u>
Patient name:
DOB:
PHN:
Contact number:

<u>Referring physician information</u>
Name:
Clinic address:
Clinic fax:
Physician Prac-ID:

Thank you for seeing my patient for the following:

Contraceptive counseling/consult (undecided method)

IUD consult +/- insertion

IUD removal

Nexplanon consult +/- insertion

Nexplanon removal

Endometrial biopsy
Reason:

PMHx:
Medications:
Past surgeries:

Is the patient postpartum:
If yes, how many weeks:

Please fax completed form to: **403-281-7785**