## Oakbay Women's Health Referral Form

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|---|
| Patient information                                 |
| Patient name:                                       |
| DOB:  |
| PHN:  |
| Contact number:                                     |
|   |
| Referring physician information                     |
| Name:   |
| Clinic address:                                     |
| Clinic fax:   |
| Physician Prac-ID:                                  |
|   |
|   |
| <del>-</del>  |
| Thank you for seeing my patient for the following:  |
|   |
| Contraceptive counseling/consult (undecided method) |
| Constance and Constance (Constance in Constance)    |
| IUD consult +/- insertion                           |
|   |
| IUD removal   |
| Nexplanon consult +/- insertion                     |
| Nexplation consult +/- insertion                    |
| Nexplanon removal                                   |
| ·   |
| Endometrial biopsy                                  |
| Reason:   |
|   |
|   |
|   |
| PMHx:   |
| Medications:  |
| Past surgeries:                                     |
|   |
| Is the nationt postpartum:                          |
| Is the patient postpartum:  If yes, how many weeks: |
| ii yes, now many weeks.                             |
|   |

Please fax completed form to: 403-281-7785