Pediatric and Adolescent Gynecology

Dr. Ellen Giesbrecht, Dr.Debra Millar, Dr. Aalia Sachedina, Dr. Nicole Todd

REFERRAL FORM

Patient will be contacted directly with appointment

FAX REFERRAL TO: 604 675 2497

INCOMPLETE REFERRALS WILL BE DECLINED

Referring Physician: _____ MSP #: _____ Tel: _____ Fax: _____
Family Physician: _____ MSP#: _____ Tel: _____ Fax: _____
(If different from referring physician)

Patient Demographics or Patient Label
Patient name: _____
PHN: _____
DOB: _____ Phone: _____
Address: _____ Cell: _____
_____ Email: _____

*NOTE BY LISTING CELL PHONE AND/OR EMAIL ADDRESS ON THIS FORM, THE PATIENT CONSENTS TO THIS AS PRIMARY COMMUNICATION FOR BOOKING APPOINTMENT

To Be Seen by	☐ **FIRST AVAILABLE**	☐ **Dr. Giesbrecht** ☐ **Dr. Millar** ☐ **Dr. Todd** ☐ **Dr. Sachedina**
Reason for Referral (Check all that apply):	Investigations Included:	Date of Procedure
☐ Vulvovaginitis ☐ Pubertal disorder – delayed, precocious ☐ Heavy menstrual bleeding ☐ Dysmenorrhea ☐ Heavy menstrual bleeding	☐ Ultrasound	
	☐ CT	
	☐ MRI	
	☐ Bloodwork	
☐ Contraception ☐ Adolescent Obstetrics ☐ Uterus/Cervix/Vaginal abnormality ☐ Other (please indicate):	☐ Culture	
	☐ Growth curve	
	☐ Consultation	

Additional Information: