ST. MICHAEL'S
UNITY HEALTH TORONTO

RAPID ACCESS GYNECOLOGY CLINIC REFERRAL FORM

8 0 2 2 1

ADDRESS: 61 QUEEN STREET EAST, 5TH FLOOR
Phone: 416-867- 7460 Ext. 48527 Fax: 416-867-7478

Referral Date:		
Patient Demographics:		**Referring Physician:**
Last Name:	First Name:	Name (print): Address (print): Telephone: Fax: Billing#:_____
Birth Date:	SMH MRN (J#):	
Primary Phone No.: ( )	Alternate Phone No.: ( )	
OHIP No.:		

*This is a procedural focused clinic where patients will be **seen for their initial consultation and 1-2 follow ups as required**. There will be no long-term or ongoing care of patients in this clinic. As they will be seen by the gynecologist who is covering that day, we are unable to accommodate gender preference requests. They will likely see a different physician at their initial consultation and follow up visit(s).*

Relevant History

INDICATION FOR REFERRAL:

- **Postmenopausal bleeding and endometrium <**5mm (ultrasound) with no structural anomalies (ie no polyps, fibroids, or anything requiring surgical removal)
- Abnormal uterine bleeding for **biopsy only** (no medical/surgical management of AUB)
- IUD insertion/exchange/removal **procedure**
- Nexplanon insertion/exchange/removal **procedure**

Patients must have had **counselling and prescription** provided by referring provider. Patients must **bring** with device that they would like inserted. *** We do not perform "difficult" IUD insertions/removals or sedation. ***

PLEASE NOTIFY YOUR PATIENT OF THE APPOINTMENT DETAILS

Appointment Date: Time: