

## **WOMEN'S HEALTH CENTRE REFERRAL FORM**



St. Michael's Health Centre 61 Queen Street East, 5th floor

Toronto, ON M5C 2T2

T: 416-867-7480 | F: 416-867-7478

Referral Date:							
Patient Demographics:							
Last Name:	First Name:	ame: Preferred			Name:		
Birth Date:	Gender:		SMH MRN (J#):				
Home Address:							
Patient Email: Patient Requ			equires Interprete	r:	OHI	P No.:	
Primary Phone No.:	Alternate Phor	ne No.:	Pati	ient Requires	Hoyer Lift -	- note max weight 400 lbs.	
GENERAL GYNECOLOGY (ENSURE APPROPRIATE DIAGNOSTIC TESTS ARE ATTACHED)							
Dr. F. Meffe			Dr. S. Mathu	Dr. S. Mathur			
Dr. R. Shah			Dr. C. McCa	Dr. C. McCaffrey			
Dr. M. Yudin			Dr. D. Rober	Dr. D. Robertson			
Dr. S. Kives			Dr. A. Simps	Dr. A. Simpson			
Dr. E. Shore			Dr. A. Nensi	Dr. A. Nensi			
Dr. S. Im's fax number: (416) 977-5572						572	
Dr. W. Steinberg			Dr. W. Steinl	Dr. W. Steinberg's fax number: (416) 864-5795			
Dr. Y. Liu			Dr. Shira Go	Dr. Shira Gold			
UROGYNECOLOGY							
Dr. D. Soroka				VULVAR CONCERN: Refer to vulva Clinic (Fax: 416-867-7478)			
PRENATAL CARE:			_	ABNORMAL PAP:			
Refer to prenatal clinic (Fax: 416-867-3742)  Grade 1 Endometrial Cancer:			<u>.</u>	Refer to colposcopy clinic (Fax: 416-867-7478)  High BMI Patients with Atypical Endometrial Hyperplasia:			
Refer to the TEAM clinic (Fax: 416-867-7478)				Refer to the TEAM clinic (Fax: 416-867-7478)			
Reason for History							
INDICATE ATTACHED RESULTS (REFERRAL WILL NOT CONSIDERED WITHOUT APPROPRIATE REPORTS)							
☐ Diagnostic Imaging ☐ Pap smear				☐ Culture results			
☐ Biopsy results ☐ Notes (consults, OR, consent, etc.)							
REFERRING PHYSICIAN							
Referring Physician/Address (print):			Telephone:	ohone: OHIP#			
Signature	ax:						
TO BE COMPLETED BY WOMEN'S HEALTH CENTRE STAFF							
Urgency: ☐ Within 2 weeks ☐ 2 – 4 weeks ☐ 4 - 12 weeks ☐ Next available							
Appointment Booked w		Date:		Time:			
Not my area of expertise							
Referral Triage Physician: Dr:					Date:		
Tolonal magor myololan. Dr.							

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