ST. MICHAEL'S
UNITY HEALTH TORONTO

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

7 3 8 6 2

Save | Reset

Referral Date:		
Patient Demographics:		
Last Name:	First Name:	Preferred Name:
Birth Date:	Gender:	SMH MRN (J#):
Home Address:		
Patient Email:	Patient Requires Interpreter:	OHIP No.:
Primary Phone No.:	Alternate Phone No.:	☐ Patient Requires Hoyer Lift – **note max weight 400 lbs.**

GENERAL GYNECOLOGY (ENSURE APPROPRIATE DIAGNOSTIC TESTS ARE ATTACHED)	
Dr. F. Meffe	**Dr. S. Mathur**
Dr. R. Shah	**Dr. C. McCaffrey**
Dr. M. Yudin	**Dr. D. Robertson**
Dr. S. Kives	**Dr. A. Simpson**
Dr. E. Shore	**Dr. A. Nensi**
Dr. S. Im	**Dr. S. Im's fax number: (416) 977-5572**
Dr. W. Steinberg	**Dr. W. Steinberg's fax number: (416) 864-5795**
Dr. Y. Liu	**Dr. Shira Gold**

UROGYNECOLOGY	
Dr. D. Soroka	**VULVAR CONCERN:** Refer to vulva Clinic (Fax: 416-867-7478)
PRENATAL CARE: Refer to prenatal clinic (Fax: 416-867-3742)	**ABNORMAL PAP:** Refer to colposcopy clinic (Fax: 416-867-7478)
Grade 1 Endometrial Cancer: Refer to the TEAM clinic (Fax: 416-867-7478)	**High BMI Patients with Atypical Endometrial Hyperplasia:** 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): Signature	Telephone: Fax:	OHIP#

TO BE COMPLETED BY WOMEN'S HEALTH CENTRE STAFF				
Urgency:	☐ Within 2 weeks	☐ 2 – 4 weeks	☐ 4 - 12 weeks	☐ Next available
Appointment Booked with Dr:			**Date:**	**Time:**
Not my area of expertise				
Referral Triage Physician: Dr:			Date:	