

PHYSICIAN REFERRAL FORM

Date of Referral: _____

PATIENT'S NAME:	Referring Physician's Name:	
	Signature:	
Address or Chart Label:	Address or Office Stamp:	
Referring Physician No.:		
Health Card No.:	VC:	
DOB:	Daytime Phone:	Evening Phone:
Office Phone:		Office Fax:
REFERRAL TO: <input type="checkbox"/>		
REASON FOR REFERRAL		
<input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Pelvis Inflammatory Disease/Salpingitis <input type="checkbox"/> Benign Ovarian Tumors <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Atypical Endometrial Hyperplasia <input type="checkbox"/> Abnormal Squamous/Glandular Cervical Cells <input type="checkbox"/> All Endometrial Carcinomas <input type="checkbox"/> Squamous & Adenocarcinomas Cervical Cells <input type="checkbox"/> Epithelial/Stromal Ovarian Tumors <input type="checkbox"/> Borderline Ovarian Tumors <input type="checkbox"/> Other, please specify: _____		
Please enclose any relevant blood work, histology, chemotherapy, radiology, imaging, surgical reports or consultations.		

Patients will be contacted directly within one week of receiving referrals to arrange an appointment. If the patient has not heard from us within this time, please contact us at 1-888-844-9838 to ensure the referral was received.