

PATIENT INFORMATION:		Last Name:		First Name:	
Date of Birth:		Address:			
City:		Prov:	PC:		HSN:
Home Phone:		Cell:		Email:	
REFERRING PRACTITIONER & CLINIC INFORMATION					
<input type="checkbox"/> Family Doctor		Name:			
<input type="checkbox"/> Nurse Practitioner		Address:			
<input type="checkbox"/> Specialist					
<input type="checkbox"/> Midwife		Phone:			
		Fax:			
REFERRAL TO:					
<input type="checkbox"/> Next Available Obstetrician Gynecologist (Except Dr. _____)			Direct Referral To:		
			<input type="checkbox"/> Dr. Davidson		<input type="checkbox"/> Dr. Payton
			<input type="checkbox"/> Dr. Rieben		<input type="checkbox"/> Dr. Sander
REASON FOR REFERRAL: CHECK MOST URGENT REASON AND INCLUDE RELEVANT DOCUMENTATION – DIAGNOSTIC LABS OR IMAGING, PRENATAL RECORDS, CONSULTS, INTERVENTIONS AND REFERRAL LETTER					
ALL OBSTETRICAL REFERRALS REQUIRE EDD :					
Prenatal Care		<input type="checkbox"/> Low Risk (Shared Care)		<input type="checkbox"/> Low Risk (Transfer of Obstetrical Care)	
High Risk Obstetrics	<input type="checkbox"/> Pre-Conceptual Counseling		<input type="checkbox"/> Hypertension		
	<input type="checkbox"/> Twins		<input type="checkbox"/> Gestational Diabetes		
	<input type="checkbox"/> Triplets or More		<input type="checkbox"/> Pre-Existing Diabetes		
	<input type="checkbox"/> Abnormal Fetal Presentation		<input type="checkbox"/> HIV Pregnancy		
	<input type="checkbox"/> Abnormal Serum Screen		<input type="checkbox"/> Trial of Labour after C-Section		
	<input type="checkbox"/> Congenital Anomalies		<input type="checkbox"/> Nuchal Translucency		
	<input type="checkbox"/> Substance Abuse in Pregnancy		<input type="checkbox"/> Small/Large Fetus		
	<input type="checkbox"/> Medical Disease in Pregnancy		<input type="checkbox"/> Obstetric Other – Specify:		
Urgent Gynecology	<input type="checkbox"/> Abnormal Pap / Colposcopy		<input type="checkbox"/> Infertility (>35 years of age)		
	<input type="checkbox"/> Abnormal Ultrasound/Pelvic Mass/Fibroids		<input type="checkbox"/> Menorrhagia with Anemia Hb < 100		
	<input type="checkbox"/> Concerning Vulvar/Vaginal/Cervical Lesion		<input type="checkbox"/> Post-Menopausal Bleeding		
	<input type="checkbox"/> Highly Suspicious for Cancer		<input type="checkbox"/> Request for Termination of Pregnancy (Please call the office 653-5970)		
	<input type="checkbox"/> First Trimester Bleeding/Possible Ectopic		<input type="checkbox"/> Severe Prolapse		
	<input type="checkbox"/> Urgent Other – Specify:				
Elective Gynecology	<input type="checkbox"/> Contraceptive Advice/Sterilization		<input type="checkbox"/> Pediatric Gynecology		
	<input type="checkbox"/> Heavy/Painful/Irregular Periods		<input type="checkbox"/> Pelvic Pain/Dyspareunia		
	<input type="checkbox"/> Menopausal/Sexual Complaints/Premenstrual Syndrome		<input type="checkbox"/> Urinary Incontinence/Vaginal Prolapse/Other bladder concerns		
	<input type="checkbox"/> Infertility Age:		<input type="checkbox"/> Vaginal Discharge/Vulvar Complaints		
	<input type="checkbox"/> Tubal Ligation Reversal		<input type="checkbox"/> Other – Specify:		
For emergency consultations please contact 306-653-5970					
NOTES:					
POOLED REFERRAL INFORMATION: Patients being offered the pooled referral option will receive the next available appointment with a specialist within this group able to treat the referring condition.					
Questions or Feedback directed to our office at 306-653-5970					
Physician Signature:				Date:	