NORTH TORONTO SURGICAL

PATIENT REFERRAL FORM

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☐ URGENT (1-3 DAYS)

PERSONAL INFORMATION

Surname, First Name _____

Health Card Number _____ **Date of Birth** _____ (dd/mm/yyyy)

Address _____
(number) (street name) (unit) (postal code) (city)

Phone Number _____ **E-Mail** _____

CONTRACEPTIVE MEDICINE

Reason for Referral

- ☐ IUD INSERTION
- ☐ CONTRACEPTIVE IMPLANT (Nexplanon®) INSERTION
- ☐ IUD INSERTION for EMERGENCY CONTRACEPTION (within 5 days post unprotected intercourse)
- ☐ CONTRACEPTION CONSULT
- ☐ CONTRACEPTIVE IMPLANT REMOVAL

Our office will contact your patient within 24 hours to book an appointment.

If patient has decided on a device, please provide your patient with a prescription for either Nexplanon® contraceptive implant, Mirena® (best suited for menorrhagia) or Kyleena® IUD, or a Copper IUD (Mona Lisa 5®, Liberte TT Standard®, Flexi-T 300)®.

☐ Patient is registered in a capitation model practice (if so, referring provider will not be negated.)

Medical History/Medication List: _____

_____

_____

Name of Referring MD/NP _____ **OHIP #** _____

Phone/Fax _____ **Date of Referral** _____ (dd/mm/yyyy)

Signature _____