Pediatric and Adolescent Gynecology

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REFERRAL FORM

Patient will be contacted directly with appointment
FAX REFERRAL TO: 604 675 2497

Referring Physician: _____ MSP #: _____ Tel: _____ Fax: _____
Family Physician: _____ MSP#: _____ Tel: _____ Fax: _____
(If different from referring physician)

Patient Demographics or Patient Label

Patient name: _____ PHN: _____
DOB: _____ Phone: _____
Address: _____ Cell: _____
_____ Email: _____

Reason for Referral (Check all that apply):	Investigations Included:	Date of Procedure
☐ Vulvovaginitis ☐ Pubertal disorder – delayed, precocious ☐ Heavy menstrual bleeding ☐ Dysmenorrhea ☐ Heavy menstrual bleeding	☐ Ultrasound	
	☐ CT	
	☐ MRI	
	☐ Bloodwork	
☐ Contraception ☐ Adolescent Obstetrics ☐ Uterus/Cervix/Vaginal abnormality ☐ Other (please indicate):	☐ Culture	
	☐ Growth curve	
	☐ Consultation	
	☐ Other (please indicate):	

Additional Information: