

# Referral Form

## Premature Ovarian Insufficiency Program

Please complete **ALL** of the following information and fax to 416-586-5941. We will contact your office with the appointment after all required information is completed.

### Patient Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
*Last Name* *First Name*

Date of Birth: \_\_\_\_\_ Health Card No. \_\_\_\_\_  
(MM-DD-YYYY)

Does patient need a translator?  No  Yes If yes, specify language \_\_\_\_\_

Does patient have any special needs?  No  Yes If yes, specify \_\_\_\_\_

Is patient taking hormone replacement?  No  Yes If yes, specify \_\_\_\_\_

Is patient taking any other medications?  No  Yes If yes, specify \_\_\_\_\_

Relevant medical history:

Investigations/Care to-date (please indicate what has been done and attach results to referral)

Pelvic Ultrasound?  No  Yes Estradiol Level  No  Yes Bone Density Scan  No  Yes

Chromosomes  No  Yes FSH  No  Yes

Lab Results (e.g. CBC, Electrolytes, Glucose, Lipids, TSH, EKG, Echo, any antibody studies)  No  Yes

Please attach copies of all diagnostic tests and lab results with this referral and fax to 416-586-5941.

### Referring Physician

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
*Last Name* *First Name*

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ OHIP Billing No. \_\_\_\_\_

### Premature Ovarian Insufficiency Program Use Only

Referral Accepted:  No  Yes Appointment Date/Time: \_\_\_\_\_

**Confidentiality Notice:** This message is only intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended recipient, please contact the sender and destroy all copies of the original.