MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Frances Bloomberg Centre for Women's and Infants' Health

Women's Unit
700 University Ave., 8th Floor South
Toronto, ON M5G 1Z5
Phone: (416) 586-4800 ext. 4621 Fax: (416) 586-5941

Referral Form

Family Planning/Contraception Clinic

This clinic will accept referrals for:

1. The insertion of an intrauterine contraceptive device (IUCD) ~ or ~
2. Laparoscopic tubal coagulation
3. Complex contraceptive issues

Once the referral has been faxed, please have your patient call 416-586-4800, ext. 4621 to book their appointment. We will not schedule an appointment until they call.

Please complete ALL of the following information and fax to 416-586-5941.

Patient Information

Name: _____ Phone: _____
Last Name *First Name*

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

Does patient need a translator? ❑ No ❑ Yes If yes, specify language _____

G:_____ P _____ A_____

Current contraception method: _____

Relevant medical history:

Recent swabs done? ❑ No ❑ Yes If yes, attach results
Recent Pap smear done? ❑ No ❑ Yes If yes, attach results

Please ensure to attach copies of swab and Pap smear results with this referral.

Referring Physician

Name: _____ Phone: _____
Last Name *First Name*

Address: _____ Fax: _____

Email: _____ OHIP Billing No._____

I am interested in a perceptorship in intrauterine procedures in the near future? ❑ Yes ❑ No

Family Planning/Contraception Program Use Only

Patient called for appt ❑ No ❑ Yes Date of call: _____ Appt date/time: _____