St. Michael's

Inspired Care.
Inspiring Science.

WOMENS HEALTH CENTRE REFERRAL FORM

St. Michael's Health Centre
61 Queen Street East, 5th floor
Toronto, ON M5C 2T2
T: 416-867-7480 | F: 416-867-7478

7 3 8 6 2

Referral Date:	
Patient Demographics:	
Last Name:	First Name:
Birth Date:	SMH MRN (J#):
Primary Phone No.: ( )	Alternate Phone No.: ( )
OHIP No.:	

GENERAL GYNECOLOGY (ENSURE APPROPRIATE DIAGNOSTIC TESTS ARE ATTACHED)

☐ Dr. S. Kives ☐ Dr. A. Simpson ☐ Dr. M. Christakis ☐ Dr. E. Shore ☐ Dr. S. Im (Fax: 416-977-5572)

☐ Dr. F. Meffe ☐ Dr. D. Robertson ☐ Dr. A. Satkunaratnam ☐ Dr. M. Yudin ☐ Dr. R. Shah

☐ Chief Resident (ER referrals only) ☐ Dr. D. Steele/E. Mocarski (Fax: 416-864-5144) ☐ Dr. W. Steinberg (Fax: 416-864-5795)

UROGYNECOLOGY (Include urine R&M and C&S results)	**MENOPAUSE CLINIC**
☐ Dr. D. Soroka	☐ Dr. M. Christakis
Reason for Referral	Relevant History

INDICATE ATTACHED RESULTS (REFERRAL WILL NOT CONSIDERED WITHOUT APPROPROTE REPORTS)

☐ Diagnostic Imaging	☐ Pap smear	☐ Culture results
☐ Biopsy results	☐ Notes (consults, OR, consent, etc.)	

REFERRING PHYSICIAN

Referring Physician/Address (print):	Telephone:	OHIP #
Signature	Fax:	

TO BE COMPLETED BY WOMEN'S HEALTH CENTRE STAFF

Urgency:	☐ Within 2 weeks	☐ 2 – 4 weeks	☐ 4 - 12 weeks	☐ Next available
Appointment Booked with Dr:			**Date:**	**Time:**
Not my area of expertise				
Referral Triage Physician: Dr:			Date:	

Form No. 73862 Rev. Aug29.2018