Dr. Nicole Todd

Obstetrics and Gynecology, MSP: 67166
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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: _____
Date of Birth: _____ Phone: _____
Address: _____ Cell: _____
_____ Email: _____

Reason for Referral (Check all that apply):	Investigations Included:	Date of Procedure
☐ Contraception	☐ Ultrasound	
☐ PCOS/Anovulation/Amenorrhea	☐ CT	
☐ Heavy menstrual bleeding	☐ MRI	
☐ Mullerian anomaly	☐ Bloodwork	
☐ Ovarian cyst	☐ Pathology (Pap, Endometrial biopsy)	
☐ Infertility	☐ Consultation	
☐ Previous Peds Gyne patient	☐ Operative Reports	
☐ Antenatal care	☐ Other (please indicate):	
☐ Other (please indicate):		

Additional Information: