GYNECOLOGY REFERRAL FORM

island health

DATE OF REFERRAL: _____	URGENCY: ☐ URGENT ☐ SEMI-URGENT ☐ NON-URGENT

PATIENT INFORMATION

NAME: _____ DOB: _____

ADDRESS: _____ PHN: _____

_____ TEL: HOME: _____

EMAIL: _____ CELL: _____

REFERRING PHYSICIAN

NAME: _____ MSP: _____

ADDRESS: _____ TEL: _____

_____ FAX: _____

REASON FOR REFERRAL		Supporting Documents	Attached	To Follow
		Ultrasound	☐	☐
		Bloodwork	☐	☐
		Cultures	☐	☐
		Pap	☐	☐
EXAM FINDINGS:		Other	☐	☐

RELEVANT MEDICAL HISTORY	MEDICATIONS

Please submit this form to **drtracyreception@hushmail.com** once filled out.

Note that only forms submitted by registered physicians in BC will be accepted.

GUIDELINES FOR DETERMINING LEVEL OF URGENCY

EMERGENT – Patient should be sent to ER at VGH

Suspected ectopic pregnancy
Bartholin's abscess (NOT SIMPLE CYST)
Significant vaginal bleeding
Suspected ovarian torsion

URGENT (2-4 weeks)

Post menopausal bleeding
Menorrhagia (Hb <100)
Complex adnexal mass
Concerning vulvar lesions

SEMI-URGENT (2-5 months)

Menorrhagia (Hb > 100)
Simple adnexal mass
Irregular periods
Vulvar disorders
Acute pelvic pain
Dysmenorrhea
Infertility

NON-URGENT (> 6 months)

Prolapse
Bartholin's cyst
Sterilization
Challenging pap tests
Chronic pelvic pain
Incontinence
Dyspareunia
Vaginal discharge
Contraception
Menopause