IWK Health

Referral
Endometriosis and Chronic Pelvic Pain Clinic

**** Please fax this form to 902−470−7061**

Patient name: _____ ❑ New Patient ❑ Re−Referral

Address: _____ Best phone number: _____

Date of birth: _____(yyyy/MON/dd) Personal health number: _____

EMAIL (REQUIRED): _____ ❑ Consent to contact by email

Is patient fluent in ❑ English ❑ Interpreter required? ❑ Yes ❑ No Language required: _____

Referring care provider	Primary care provider
Name: _____	Name: _____
❑ PCP ❑ Specialty (type): _____	Phone: _____ Fax: _____
Phone: _____ Fax: _____	License No: _____
License No: _____	

Who agrees to continue care? ❑ Primary care provider ❑ Referring care provider

Inclusion Criteria:

Please select referral reason:

❑ **Advanced endometriosis** (ovarian endometrioma, deep endometriosis, extra−pelvic endometriosis)

❑Surgical diagnosis OR ❑Imaging/clinical diagnosis. **Please attach all relevant surgical and imaging reports.**

❑Trying to conceive

❑**Chronic pelvic pain**: lasting more than 6 months and unresponsive to first line management. Patient must have been assessed by gynecologist within the **past 5 years** for this problem and a **consult letter must be included with referral**.

❑ Gynecologist letter attached

Treatment tried: ❑ OCP ❑ progestin ❑ IUD ❑ GnRH analogue ❑ surgery

Urgent referral − provide details: _____

_____

Other relevant information: _____

Exclusion Criteria:

Adolescents younger than 16
Vestibulitis/vulvodynia/introital dyspareunia only
Uro−gyne (mesh, tape complications, prolapse)
Currently pregnant/post−partum less than 6 months
No valid health card

Age older than 55
Post−menopausal (surgical or natural)
Myofascial/back pain only
Neuropathic pain only
Unstable or untreated psychiatric issues
Untreated/ongoing substance use disorder

Patient will not be triaged until ALL information regarding previous investigations is received

Signature / Status	Print Name	Date (yyyy/MON/dd)

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