IWK Health

# Referral
## Maritime Centre for Pelvic Floor Health
### *Division of Female Pelvic Medicine and Reconstructive Surgery/Urogynecology*

K07002307 Jun/7/2002 M
SCA,TEST Visit
ER0000145/12 **HCN:** 22222222
Van den Hof, TEST / TEST, Maureen
Dec/8/2012

**Please FAX this completed form to: 902−470−7061**

**Relevant Documents included:** ❑ U/A ❑ Imaging ❑ Prior OR Reports ❑ Other:_____

**PATIENT EMAIL (REQUIRED):** _____ ❑ Consent to contact by email
**(will add Email consent form ID here)**

Patient's Name: _____
Patient's Address: _____
_____
Date of Birth (yyyy/MON/dd): _____
Health Card Number: _____
Phone Number: _____
❑ First time referral ❑ Re−referral

Referring Physician: _____
Family Physician: _____
Date of Referral: _____

**REASON FOR REFERRAL (check all that apply):**

❑ Pessary Fitting
❑ Pelvic Organ Prolapse
❑ Stress Urinary Incontinence
❑ Overactive Bladder Symptoms
❑ Acute Symptom Onset
❑ Difficulty with Bladder Emptying
❑ Recurrent Urinary Tract Infections
❑ Bowel Incontinence
❑ Obstructed Defecation
❑ Genital Tract Fistulas
❑ Mesh Related Complications
❑ Benign Vulvar and Vaginal Lesions
❑ General Gynecology

**PHYSICAL EXAM FINDINGS**

❑ Normal, no concerns
❑ Vulvovaginal Atrophy
Prolapse − If yes, check all that apply: ❑ Cystocele ❑ Rectocele ❑ Uterine ❑ Beyond vaginal introitus
Other: _____
_____
_____
Relevant Details: _____
_____
_____
_____
_____
Does patient have moderate to severe dementia? ❑ Yes ❑ No
Does patient use mobility aids? ❑ Yes ❑ No Type: _____

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