Referral Form for Urogenital Health Program

PATIENT DETAILS			
Name:		Address:	
Date of Birth:	Telephone #:	Email:	
REFERRING DOCTOR			
Name:		Address:	
Telephone #:	Fax #:	Email:	
REASON FOR REFERRAL (please check ☑ all that apply)			
☐ Vaginal Dryness	☐ Dyspareunia	☐ Stress Incontinence	☐ Vaginal Itching
☐ Vaginal Laxity	☐ Urge Incontinence	☐ Lichen Sclerosus/ Lichen Planus (Please attach biopsy report)	
☐ Recurrent Bladder Infections	☐ Other		
OBSTETRIC & GYNAECOLOGICAL HISTORY			
LMP:	☐ Menopausal	☐ Post Natal	
# Pregnancies:		Mode of Delivery:	
Gynae Conditions: ☐		Pelvic Radiation: ☐	
Gynae Surgery: ☐		Prolapse/Mesh Repairs: ☐	
☐ Current HRT	☐ Past HRT	☐ Current Vaginal Estrogen	
Latest PAP Smear Date:		Result:	
MEDICAL HISTORY			
Medical Conditons:			
☐ Breast Cancer	☐ Chemotherapy	☐ Surgery	☐ Radiotherapy
☐ Other Cancer (please specify)			

Please fax this referral to Institute for Hormonal Health and your patient will be contacted for an appointment.

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