GYNECOLOGY
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Dr. Du Toit Referral Form

Patient Name: Address: Postal Code: PHN: DOB: Phone: Email:	Doctor Name: Address: Postal Code: Clinic Name: Phone: Fax: Prac ID:

****Please note Dr. Du Toit does NOT provide care for Obstetrics and cannot accommodate Major Surgical Requests. ****

If any NEW concerns develop that patient was not originally referred for; a new/updated referral will be required PRIOR to booking a follow-up appointment.

To avoid any delays in triaging, please provide copies of all relevant labs with your referrals. Please update us as well, if any patient contact information has changed at any point in time. Please notify your patient to bring a translator to all their appointments if required.

Does your patient Qualify/have all pre-requisites for this referral? (Check all that apply.)

- ☐ Patient is above the age of 15.
- ☐ Patient does NOT require surgical intervention.
- ☐ All relevant investigations have been attached.
- ☐ Patient is NOT currently Pregnant.
- ☐ Patient is NOT requesting fertility treatment. (Please redirect to RFC if fertility treatment desired)
- ☐ Patient requires a translator and will have someone accompany them for appointments.

Check all that apply:

- ☐ Pelvic Ultrasound Pending
- ☐ Pelvic Ultrasound Attached
- ☐ IUD Rx given to patient
- ☐ Recent PAP attached
- ☐ Recent Mammogram attached
- ☐ Blood Work Pending
- ☐ Blood Work Attached
- ☐ List of Medication Attached

REFERRAL REASON/ Clinical history: