

Date of Referral (DD/MM/YYYY): \_\_\_\_\_

**Referring Physician Information**

**Primary Care Physician Information**

Same as Referring Physician

Referring Physician OHIP Billing #  
( ) ( )  
Phone # Fax #

Primary Physician OHIP Billing #  
( ) ( )  
Phone # Fax #

**Patient Information**

Patient Name Date of Birth (DD / MM / YYYY)  
( ) ( )  
Street Address Home Phone # Business/Other Phone #  
City, Province Postal Code Health Card # Version Expiry date

**Reason for Referral**

Date of Referral (DD/MM/YYYY): \_\_\_\_\_

Referral Reason (Diagnosis): \_\_\_\_\_

- New Referral  Transfer care from outside RVH  2<sup>nd</sup> Opinion  
 Repeat Referral

**Clinical & Diagnostic Information**

**Indication for colposcopic evaluation**

- Most recent cytology results (Required)**  
 Clinical information  
 Imaging (Ultrasound, CT Scan, MRI)  
 Surgical Pathology  
 Operative Note  
 Other \_\_\_\_\_

- Abnormal cervical cytology  Cervical lesion  
 Abnormal vaginal cytology  Vaginal lesion  
 HPV positivity  Vulvar lesion  
 DES exposure  Perianal lesion  
 Other \_\_\_\_\_

**Please note:** This program provides care for patients suspected to have pre-invasive **lower genital tract neoplasia only**. If your patient requires a benign gynecology review, please refer directly to a gynaecologist. If you suspect malignancy, please refer directly to a gynaecologic oncologist.

**Fax your completed form to 705-797-2967.**

**This patient remains under the care of the referring physician until seen by our program.**

**Please ensure your patient is aware of referral. Patients will be contacted directly with appointment.**

