



Date: _____ (DD / MM / YYYY)

A: PATIENT INFORMATION ☐ New Patient ☐ Re-Referral	
Patient Name: _____	PHN: _____
Email: _____	Phone number: _____
Address: _____	City/Town: _____
Date of Birth: _____ (DD/MM/YYYY)	Pronouns: _____
Fluent English ☐ Y ☐ N Interpreter Required ☐ Y ☐ N Language _____ Identify as Indigenous ☐ Y ☐ N	
B: REFERRING CARE PROVIDER	C: PRIMARY CARE PROVIDER (if different from referring)
Name: _____ MSP# _____	Name: _____ MSP# _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
☐ GP ☐ Specialist ☐ Other: _____	
D: ADVICE CALL <i>Note: this is for patients not being referred to the clinic</i>	
☐ Advice call for community gynecologists (call will be scheduled within one week). Details: _____	
E: CLINIC REFERRAL REQUIRED: Complete all fields	
1. Who agrees to continue care?	☐ Referring provider, or ☐ Primary provider
2. Does the patient have any exclusion criteria ? Lives outside BC/YT or No MSP Post-menopausal (surgical or natural) Age <16 or > 55 Vestibulitis/vulvodynia/introital dyspareunia only Currently pregnant/postpartum < 6 mos Myofascial/back pain only Unstable/Untreated psychiatric issues Neuropathic pain only Untreated/ongoing substance use Urogynae (mesh, tape complications, prolapse)	☐ No
3. <u>SELECT (1) ONE REASON FOR REFERRAL:</u> (A) Confirmed surgical or imaging/clinical diagnosis of advanced endometriosis: ovarian endometrioma >3cm deep endometriosis (bowel, ureter, bladder) extra-pelvic endometriosis OR (B) Persistent pelvic pain unresponsive to first line management <u>AND</u> has been assessed and treated by a gynecologist in the last 3 years?	☐ <u>If reason (A)</u> ☐ Supporting surgical, pathology, and/or imaging reports, and consult reports attached (mandatory) Patient wants surgery? (select one) ☐ Yes ☐ No ☐ Undecided ☐ <u>If reason (B)</u> ☐ Gyne consult letter attached (mandatory) Treatments tried (select all that apply): ☐ IUD ☐ Surgery ☐ Progestin ☐ CHC/combined contraception ☐ GnRH agonist/antagonist
4. Is this an URGENT referral?	☐ No ☐ Yes, details: _____
5. Other relevant information	(optional) ☐ see attached

Fax completed referral and required documents to: 604-875-2569

Referrals will not be accepted until all information is received and all fields are complete. Patients accepted into the clinic will be contacted directly by our office.

The clinic has a standardized approach and is program-based. Your patient will be scheduled with the next available physician to minimize waiting time.

We do not assume opioid prescribing. There are no addiction services in our clinic.