

Gynecological Referral Form

Patient Information		
Name		
Date of Birth mm / dd / yyyy	Age	Phone Number
Address		
City	Province	Postal Code
Reason for referral (if referring for Pap test, date of last Pap):		
History of abnormal cervical cytology?		
Working diagnosis (if relevant):		
History of treatment for this condition (if relevant):		
Please indicate which test(s) you would like performed with a checkmark <input checked="" type="checkbox"/> :		
<input type="checkbox"/> Pap test	<input type="checkbox"/> Bacterial vaginosis	<input type="checkbox"/> Chlamydia trachomatis
<input type="checkbox"/> Candida albicans	<input type="checkbox"/> HPV DNA (recommended if 30yrs+ or hx of ASCUS)	<input type="checkbox"/> Trichomonas vaginalis
		<input type="checkbox"/> Neisseria gonorrhoea
Referring Practitioner		
Name		
Phone Number	Fax Number	Email
I require a written report of the exam findings: <input type="checkbox"/> Yes <input type="checkbox"/> No (Please note: a \$25 fee for the report will apply. However, laboratory results will be faxed to you at no charge.)		

Please complete this form and fax, mail or scan & email to:

Attn: Tara Marcinkowski BAH ND
2927 Dundas Street West
Toronto, ON M6P 1Z1
Email: tara@healthandwellbeing.info
Fax: 416.604.9665

When your referral form is received, you will be emailed the fee breakdown for the testing you have requested.

