

Dr. Grace Yeung HBSc, MD, MHM, FRCSC

Obstetrics & Gynecology
Minimally Invasive Surgery
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For referral forms: www.obgygracey.com

GENERAL OBSTETRICS/GYNECOLOGY REFERRAL FORM

Referral Date (DD/MM/YY): ___/___/___

Referral instructions:

1. Fax this referral form to **(647) 361-0451**
2. Include copies of all appropriate test results
3. Office will return a fax to the referring provider with patient appointment time

Patient Information (or affix label)

First Name: _____

Last Name: _____

DOB (DD/MM/YY): ___/___/___

Address: _____

Home #: (____) _____

Cell #: (____) _____

Health Card #: _____ VC: _____ Expiry: _____

OBSTETRICS	GYNECOLOGY
<input type="checkbox"/> Complete Prenatal Care	<input type="checkbox"/> Minimally invasive surgery (laparoscopy, hysteroscopy, vaginal surgery)
<input type="checkbox"/> Shared Prenatal Care	<input type="checkbox"/> Menstrual Bleeding Disorder (menorrhagia, abnormal uterine bleeding, irregular menses)
<input type="checkbox"/> Consult only	<input type="checkbox"/> Post menopausal bleeding
LMP (DD/MM/YY): ___/___/___	<input type="checkbox"/> Ovarian/adnexal mass/cyst
EDC (DD/MM/YY): ___/___/___	<input type="checkbox"/> Polyp (endometrial/cervical)
Gestational age: _____ (weeks)	<input type="checkbox"/> Fibroids
Please attach (if relevant):	<input type="checkbox"/> Pelvic pain/Endometriosis
<input type="checkbox"/> Antenatal I & II	<input type="checkbox"/> Incontinence/Prolapse (Urogynecology)
<input type="checkbox"/> Prenatal labs (Hep B, HIV, Rubella, Syphilis, CBC, Group and Screen, TSH)	<input type="checkbox"/> Colposcopy (abnormal pap, condyloma, vulvar/cervical lesion)
<input type="checkbox"/> Urine C&S	<input type="checkbox"/> Vulvar/Vaginal disorder
<input type="checkbox"/> Pap smear	<input type="checkbox"/> Contraception
<input type="checkbox"/> Swabs	<input type="checkbox"/> Pediatric & Adolescent Gynecology
<input type="checkbox"/> Prenatal screening (IPS/MSS/FTS/NIPT)	<input type="checkbox"/> Infertility/Miscarriage
<input type="checkbox"/> Ultrasound or sonohysterography	<input type="checkbox"/> Menopause/Hormone disorder
<input type="checkbox"/> Relevant labs/consults/OR/imaging	<input type="checkbox"/> Sexual medicine
<input type="checkbox"/> Medication history	<input type="checkbox"/> Other: _____

Clinical History & Past History:

Referring Provider Information (or affix stamp):

Provider Name: _____

Address: _____

Billing #: _____

Fax: (____) _____

Phone: (____) _____

To be completed by Office Staff: Appt scheduled: _____ (Date) _____ (Time)

Please fax completed referral form to **(647)361-0451**.

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