Hamilton Birth Control & Sexual Health Clinic

Hamiltonbirthcontrolclinic.ca

Please Fax Referrals to
289 - 919 - 2505

Patient's Name: ____________________

Health card Number: ____________________

Date of Birth : ____________________

Address: ____________________

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Contact Information: ____________________
(Attach Patient label here)

Referring Physician / NP : ____________________

Billing Number : ____________________

Fax: ____________ Phone: ____________

Date of Referral : ____________________

☐ Please check this box if this patient is rostered to a FHO/FHT. We will aim to have appointments booked with a Physician with focused practice designation but this may affect wait times.

Signature : ____________________

List of Medications:

Please Indicate Urgency:
☐ Very Urgent (2 Weeks) ☐ Urgent (6 Weeks) ☐ Routine (2-3 Months)

Significant Past Medical History :

☐ CPP attached

Reason For Referral

Birth Control:

- ☐ Birth control options counselling
- ☐ IUD Consult and Insertion - 2 different appointments
- ☐ IUD Insertion only ☐ Difficult Insertion
  By selecting this option, you indicate the patient has been appropriately counselled and will bring their IUD to the appointment
- ☐ IUD Removal ☐ Difficult Removal

Type of IUD : ____________________
We Prefer Mona Lisa 5 year standard copper IUDs if copper

- ☐ Nexplanon Consult and Insertion - 2 different appointments
- ☐ Nexplanon Insertion only
  By selecting this option, you indicate the patient has been appropriately counselled and will bring their device to the appointment
- ☐ Nexplanon Removal

Abortion:

- ☐ Medication Abortion - Mifegymiso script and follow up
  3 different appointments

☐ Other: ____________________

Menopause/Women's Issues:

- ☐ Perimenopausal/Postmenopausal abnormal uterine bleeding requiring endometrial biopsy
- ☐ Abnormal uterine bleeding/thickened endometrium on pelvic U/S
- ☐ Vulvar skin conditions requiring biopsy
  Please write your differential____________________
- ☐ Physical symptoms of menopause with the following indication for HRT: ☐ Vasomotor Sx ☐ GU Sx ☐ Bone protection
  ☐ Please confirm no C/I including no Hx of VTE/CVD
  Please note we do not see patients for low libido or testosterone prescription

Sexual Health:

- ☐ STI testing Multi-Site testing as indicated, lab on site
- ☐ STI Management for positive result

Please note we do not treat HIV infections, please refer to HHS SIS clinic

- ☐ PReP counselling and prescription
- ☐ PAP Test - For age >25 no other concerns
  ☐ Routine
  ☐ Repeat Last Pap Result: ____________ Date: ____________

Please note that certain referrals are inappropriate for our service. We are unable to assist with vaginismus, dyspareunia, chronic pelvic pain, endometriosis, adenomyosis, ovarian cysts, pelvic organ prolapse, and pessary fitting.

Date and Time of Appointment (In office use only)

DATE: ____________________ TIME: ____________________

☐ Patient Notified
☐ Please Notify Patient

Unit 262 - 2 King Street, West. Hamilton, ON L8P 1A1
PHONE: 289 - 225 - 4322
FAX: 289 - 919 - 2505
HBCC@jacksonsquaremed.ca

Thank you for your referral. We will contact patients directly with their appointment details.