



PATIENT LABEL:

REQUIRED FOR REFERRAL TO BE ACCEPTED
PATIENT HISTORY MUST BE ATTACHED
CURRENT MEDICATIONS, ALLERGIES, ANY PRIOR MEDICAL HISTORY/SURGERIES

PLEASE SELECT AND ELABORATE ON THE CONCERN(S) NEEDED TO BE ADDRESSED:

MEDICAL DOCTOR:

- | | | |
|---|---|--|
| <input type="checkbox"/> Menopause Management | <input type="checkbox"/> Hormone Therapy by NAMS certified MD | <input type="checkbox"/> IUD / NEXPLANON Insertion |
| <input type="checkbox"/> Vaginal Concerns | <input type="checkbox"/> Pelvic Concerns | <input type="checkbox"/> Contraception Counselling |
| <input type="checkbox"/> Menstrual Concern | <input type="checkbox"/> PAP Smear | <input type="checkbox"/> Other_____ |

PELVIC FLOOR PHYSIOTHERAPY:

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Pelvic Pain / Dyspareunia | <input type="checkbox"/> Pre / Postnatal | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Incontinence with EMSELLA By Maud Program |
| <input type="checkbox"/> Pelvic Dysfunction | <input type="checkbox"/> Sexual Function | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Pessary Care | <input type="checkbox"/> Other_____ | | |

OTHER SERVICES:

- | | | |
|---|--|--|
| <input type="checkbox"/> Women's Health Nutrition | <input type="checkbox"/> EMSELLA By Maud Program for incontinence / sexual fuction | <input type="checkbox"/> Sex Counselling |
|---|--|--|

REFERRING PRACTITIONER:

PRAC ID: