WELL ONE

Medical Centre

IUD Referral Form

Patient Information		
Last Name :	First Name :	D.O.B :
OHIP # :	Cell Phone :	Home Phone :
Address :		
City	Province	Postal Code:

Referring Physician Information	
Referring Physician:	Billing #:
Phone :	Fax :
Office Address:	

Referral Information

☐ Consultation only ☐ Consultation and Insertion ☐ IUD Removal

Reason for IUD

☐ Contraception ☐ Menorrhagia

Current Contraception:	OB/GYNE Hx:

Include any relevant laboratory or diagnostic imaging reports

• BHCG Results ☐Attached	• Pelvic Ultrasound (if used for menorrhagia) ☐Attached

Physician Signature: _____ **Date:** _____

WELL ONE

Ⓐ 18 Yonge Street, Toronto Ontario, M5E 1Z8 Canada Ⓟ (647) 748-5663 Ⓕ (647) 740-7166 Ⓦ www.wellone.ca