FAX PATIENT REFERRAL TO:
REFERRAL MANAGEMENT SERVICES
FAX: 1-855-355-1921
PHONE: 1-833-337-7770

OBSTETRICIAN/GYNECOLOGIST REFERRAL: YORKTON

PATIENT INFORMATION:	Last Name:		First Name:
Date of Birth: DD/MMM/YYYY	Address:		
City:	Prov:	PC:	HSN:
Home Phone:	Work Phone:		Cell Phone:

REFERRING PRACTITIONER & CLINIC INFORMATION:

☐ Family Doctor ☐ Nurse Practitioner ☐ Specialist ☐ Midwife	Name: Address: Phone: Fax:

REFERRAL TO:

☐ Next Available Obstetrician Gynecologist
Except Dr._____

☐ Specific Dr._____

☐ Gynecologic Oncology
(suspected cancer diagnosis)

☐ Maternal Fetal Medicine Clinic

REASON FOR REFERRAL: *CHECK MOST URGENT REASON AND INCLUDE RELEVANT DOCUMENTATION – DIAGNOSITC LABS OR IMAGING, PRENATAL RECORDS, CONSULTS, INTERVENTIONS AND REFERRAL LETTER.*

ALL OBSTETRICAL REFERRALS REQUIRE EDD: DD/MMM/YYYY

Prenatal Care	☐ Low Risk (Shared Care)	☐ Low Risk (Transfer of Obstetrical Care)
High Risk Obstetrics	☐ Twins	☐ Hypertension
	☐ Higher Order Multiple Gestation	☐ Gestational Diabetes
	☐ Abnormal Prenatal Screen	☐ Pre-Existing Diabetes
	☐ Congenital Anomalies	☐ HIV Pregnancy
	☐ Medical Disease in Pregnancy Specify:	☐ High Risk Other:
	☐ Substance Abuse in Pregnancy	☐ Intrauterine Growth Restriction
Urgent Gynecology	☐ Abnormal Pap/Colposcopy	☐ Infertility (Over 35 Years of Age)
	☐ Abnormal Ultrasound/Pelvic Mass	☐ Menorrhagia with Anemia Hb <100
	☐ Concerning Vulvar/Vaginal/Cervical Lesion	☐ Post-Menopausal Bleeding
	☐ Cancer or Highly Suspicious For Cancer	☐ Urgent Other:
Elective Gynecology	☐ Contraceptive Advice/Sterilization	☐ Pediatric Gynecology
	☐ Heavy/Painful/Irregular Periods/Fibroids	☐ Pelvic Pain/Dyspareunia
	☐ Infertility (Age:_____)	☐ Urinary Incontinence/Vaginal Prolapse
	☐ Menopausal/Sexual Complaints/Premenstrual Syndrome	☐ Vaginal Discharge/Vulvar Complaints
	☐ Other Specify:	

NOTES:

POOLED REFERRAL INFORMATION: Patients offered the pooled referral option will receive the next available appointment with a specialist able to treat the referring condition. Specialists who choose to pool their referrals but do not share an office may use the Referral Management Service at eHealth Saskatchewan to manage the intake of patient referrals. This service shares de-identified referral information with all the specialists in this group to aid in reducing patient wait times and improving the patient experience.

Physician Signature:	Date:
Redirecting Specialist: ☐ Pooled ☐ Specific Dr._____	Date:

Updated: 8 Aug 2021