

**OBSTETRICIAN/GYNECOLOGIST REFERRAL: MOOSE JAW**

<b>PATIENT INFORMATION:</b>		Last Name:		First Name:	
Date of Birth: DD/MMM/YYYY		Address:			
City:		Prov:	PC:	HSN:	
Home Phone:		Work Phone:		Cell Phone:	
<b>REFERRING PRACTITIONER &amp; CLINIC INFORMATION:</b>					
<input type="checkbox"/> Family Doctor <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Specialist <input type="checkbox"/> Midwife		Name: Address: Phone: Fax:			
<b>REFERRAL TO:</b>					
<input type="checkbox"/> Next Available Obstetrician Gynecologist Except Dr. _____			<input type="checkbox"/> Gynecologic Oncology <i>(suspected cancer diagnosis)</i>		
<input type="checkbox"/> Specific Dr. _____			<input type="checkbox"/> Maternal Fetal Medicine Clinic		
<b>REASON FOR REFERRAL:</b> CHECK MOST URGENT REASON AND INCLUDE RELEVANT DOCUMENTATION – DIAGNOSTIC LABS OR IMAGING, PRENATAL RECORDS, CONSULTS, INTERVENTIONS AND REFERRAL LETTER.					
<b>ALL OBSTETRICAL REFERRALS REQUIRE EDD:</b> DD/MMM/YYYY					
<b>Prenatal Care</b>		<input type="checkbox"/> Low Risk (Shared Care)		<input type="checkbox"/> Low Risk (Transfer of Obstetrical Care)	
<b>High Risk Obstetrics</b>	<input type="checkbox"/> Twins		<input type="checkbox"/> Hypertension		
	<input type="checkbox"/> Higher Order Multiple Gestation		<input type="checkbox"/> Gestational Diabetes		
	<input type="checkbox"/> Abnormal Prenatal Screen		<input type="checkbox"/> Pre-Existing Diabetes		
	<input type="checkbox"/> Congenital Anomalies		<input type="checkbox"/> HIV Pregnancy		
	<input type="checkbox"/> Medical Disease in Pregnancy Specify:		<input type="checkbox"/> High Risk Other:		
<input type="checkbox"/> Substance Abuse in Pregnancy		<input type="checkbox"/> Intrauterine Growth Restriction			
<b>Urgent Gynecology</b>	<input type="checkbox"/> Abnormal Pap/Colposcopy		<input type="checkbox"/> Infertility (Over 35 Years of Age)		
	<input type="checkbox"/> Abnormal Ultrasound/Pelvic Mass		<input type="checkbox"/> Menorrhagia with Anemia Hb <100		
	<input type="checkbox"/> Concerning Vulvar/Vaginal/Cervical Lesion		<input type="checkbox"/> Post-Menopausal Bleeding		
	<input type="checkbox"/> Cancer or Highly Suspicious For Cancer		<input type="checkbox"/> Urgent Other:		
<b>Elective Gynecology</b>	<input type="checkbox"/> Contraceptive Advice/Sterilization		<input type="checkbox"/> Pediatric Gynecology		
	<input type="checkbox"/> Heavy/Painful/Irregular Periods/Fibroids		<input type="checkbox"/> Pelvic Pain/Dyspareunia		
	<input type="checkbox"/> Infertility (Age: _____)		<input type="checkbox"/> Urinary Incontinence/Vaginal Prolapse		
	<input type="checkbox"/> Menopausal/Sexual Complaints/Premenstrual Syndrome		<input type="checkbox"/> Vaginal Discharge/Vulvar Complaints		
	<input type="checkbox"/> Other Specify:				
<b>NOTES:</b>					
<p><b>POOLED REFERRAL INFORMATION:</b> 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.</p>					
Physician Signature:				Date:	
<b>Redirecting Specialist:</b> <input type="checkbox"/> Pooled <input type="checkbox"/> Specific Dr. _____				Date:	