

**OBSTETRICS/GYNECOLOGY REFERRAL: PROVINCIAL**

<b>PATIENT INFORMATION:</b>		Last Name:		First Name:	
Date of Birth: DD/MMM/YYYY		Age:		Address:	
City:		Prov:	PC:		HSN:
Home Phone:		Work Phone:			Cell Phone:
Requires Interpreter <input type="checkbox"/> YES <input type="checkbox"/> NO		Language:		Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/> Undeclared	
<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:		Phone:	
		Address:		Fax:	
<b>REFERRAL TO: ALERT – FOR EMERGENT REFERRALS CONTACT ON CALL PHYSICIAN – 866-766-6050</b>					
<input type="checkbox"/> Next Available Specialist		<input type="checkbox"/> Specific Dr. / Office		Site requested:	
Except Dr. _____		<input type="checkbox"/> Out of town clinic		<input type="checkbox"/> Saskatoon <input type="checkbox"/> Prince Albert <input type="checkbox"/> Regina <input type="checkbox"/> Yorkton <input type="checkbox"/> Moose Jaw <input type="checkbox"/> North Battleford	
<b>REASON FOR REFERRAL: CHECK PRIMARY REASON FOR REFERRAL AND INCLUDE RELEVANT DOCUMENTATION</b>					
<b>ALL OBSTETRICS REFERRALS REQUIRE EDC OR LMP: _____</b>					
<b>Prenatal Care</b>	<input type="checkbox"/> Low Risk (Shared Care)		<input type="checkbox"/> Low Risk (Transfer of Care)		
<i>Please Note: If appropriate and available, low risk prenatal referrals may be directed to low-risk obstetrical provider</i>					
<b>High Risk Obstetrics</b>	<input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Est. fetal weight <10 or >90 percentile <input type="checkbox"/> Dichorionic Twins <input type="checkbox"/> Hypertension - pre-existing/gestational <input type="checkbox"/> Trial of Labour After C-Section <input type="checkbox"/> Abnormal Fetal Presentation		<input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Substance Use <input type="checkbox"/> HIV <input type="checkbox"/> BMI >40 <input type="checkbox"/> Other (please specify): <input type="text"/>		
<b>Maternal Fetal Medicine</b>	<input type="checkbox"/> Alloimmunization <input type="checkbox"/> Triplets or higher order multiples <input type="checkbox"/> Monochorionic twins (MCDA/MCMA) <input type="checkbox"/> Pre-conceptual counselling <input type="checkbox"/> Complex cardiac disease (specify): <input type="checkbox"/> Complex medical condition (specify):		<input type="checkbox"/> Abnormal umbilical artery Dopplers <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Abnormal Prenatal Screen/Nuchal Translucency <input type="checkbox"/> Other (please specify): <input type="text"/>		
<b>Urgent Gynecology</b>	<input type="checkbox"/> Abnormal Pap/High risk HPV/Colposcopy <input type="checkbox"/> Pelvic Mass (please include size in letter) <input type="checkbox"/> Concerning Vaginal/Vulvar/Cervical Lesion <input type="checkbox"/> Cancer or Highly Suspicious of Cancer <input type="checkbox"/> Menorrhagia with anemia (Hb<100) Hb: ____		<input type="checkbox"/> Post Menopausal Bleeding <input type="checkbox"/> Severe pelvic pain – ER visits or narcotics <input type="checkbox"/> Other (please specify): <input type="text"/>		
<b>Elective Reproductive Gynecology</b>	<input type="checkbox"/> Contraception/Sterilization <input type="checkbox"/> Abnormal or heavy menses – Hb: ____ <input type="checkbox"/> Symptomatic fibroids <input type="checkbox"/> Infertility (age <35, >1 year duration) <input type="checkbox"/> Pediatric Gynecology (please specify): <input type="checkbox"/> Menopausal complaints		<input type="checkbox"/> Pelvic Pain/Dyspareunia/Sexual Concerns <input type="checkbox"/> Vaginal Discharge/Vulvar Complaints <input type="checkbox"/> Gender care <input type="checkbox"/> Other (please specify): <input type="text"/>		
<b>Reproductive Endocrinology and Infertility</b>	<input type="checkbox"/> Infertility >age 35 <input type="checkbox"/> Preimplantation genetic testing <input type="checkbox"/> Infertility with known endometriosis <input type="checkbox"/> Infertility with male factor concerns <input type="checkbox"/> Previous tubal sterilization – desiring IVF <input type="checkbox"/> Tubal Reanastomosis		<input type="checkbox"/> Recurrent pregnancy loss <input type="checkbox"/> Fertility care LGBTQ2 <input type="checkbox"/> Fertility preservation – elective (see p2 if cancer) <input type="checkbox"/> Other (please specify): <input type="text"/>		
<b>Urogynecology</b>	<input type="checkbox"/> Severe Prolapse (procidentia, erosions, etc) <input type="checkbox"/> Prolapse, mild to moderate <input type="checkbox"/> Urinary Incontinence/Other bladder concerns		<input type="checkbox"/> Obstetrical Anal Sphincter Injury <input type="checkbox"/> Other (please specify): <input type="text"/>		

**PLEASE COMPLETE PAGE 2 OF REFERRAL FORM**

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**For Triage Purposes:** provide a referral letter (below or attached) with detailed information explaining patient complexity and comorbidities and attach previous specialist consults, labs, imaging, prenatal records, etc. Physical exam findings are especially important for triaging lesions and must be included.

**Pooled Referral Information:** Patients offered the pooled referral option will receive the next available appointment with a specialist able to treat the referring condition. This service shares de-identified referral information with all the specialists in this group to aid in reducing patient wait times and improve the patient experience.

Physician Signature:

**Redirecting Specialist  
(Specialist Use Only):**

- Pooled  
 Specific Dr. \_\_\_\_\_

Date:

Date:

**First trimester bleeding/cramping**

**Saskatoon:** Refer to Early pregnancy program – see referral form

**Regina:** Refer to Early Pregnancy Assessment Clinic – fax: 306-766-4124

**Regional centers:** Refer to OBGYN on call if urgent consult required

**Obstetrical Considerations**

**Prenatal referrals (all centers)**

Include with referral:

-prenatal records, ultrasound reports, labs (CBC, Type and screen, prenatal panel, Chlamydia, Gonorrhea, Ferritin, TSH, urine culture, etc)

- aneuploidy screening
- most recent pap smear
- previous specialist reports/consults
- previous operative reports

- ***Due date or LMP must be included***

**Conditions warranting a phone call to the on-call physician:**

Blood pressure greater than 160/100

Ultrasound report of umbilical artery Dopplers with absent or reverse end diastolic flow

Ultrasound report of BPP <6/8

Ultrasound report of IUGR <5<sup>th</sup> centile

Cervical length <2.5cm

Ectopic pregnancy

Molar pregnancy

**Pregnancy termination care**

**Saskatoon:** Patient is to self-refer – call 306-655-7637

**Regina:** Patient is to self-refer – call 306-766-0586

**Prince Albert:** Only Medical terminations up to 10 weeks; otherwise refer to Saskatoon Early Pregnancy Program

**Gynecologic Oncology**

make referrals directly to Sask Cancer Agency

**Gynecologic Considerations**

**Menorrhagia (all centers)**

Please include most recent hemoglobin, ferritin, imaging reports, and pap smear

**Pelvic masses (all centers)**

Please include dimensions and/or imaging reports

**Abnormal pap results, high risk HPV and other colposcopic requests (all centers)**

Please include pap result, pertinent lab and pathology reports and previous colposcopic reports if applicable

**Incontinence and prolapse consider referral to Pelvic Floor Pathway (referral form SHA 0260)**

**Saskatoon:** fax #306-655-7918

**Regina:** fax # 306-766-7551

**Fertility preservation for cancer patients (all centers)**

Call Aurora fertility clinic directly at 306-653-5222