# Summerside Gynecology Referral

# Fax to: 902-288-1512 Email to: summersideobsgynereferrals@ihis.org

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| **Referral to:**  **Next available appointment**  Dr. Beth Barbrick-Crozier  Dr. Hani Farag  Dr. Brianne Lewis  Dr. Akin Ojuawo |

**If choosing a specific physician, please be aware the wait could be longer.**

**Has the patient previously seen this specific Physician?**

**Date of visit:**

**Is this a second opinion: Yes  No**

**Please complete in full:**

*Be aware that if relevant items are missing, triage will be delayed until the referral is complete.*

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| **Patient Information** | | | | |
| **First Name:** | | **Last Name:** | **DOB (YYYY/MM/DD):** | **PHN:** |
| **Preferred Pronoun:**  He/Him  She/Her  They/Them | **If Minor, consent to contact parent with appointment**  Yes No | | **Phone #:** | **Alternate Phone#:** |
| **Address:** | | **City:** | **Province:** | **Postal Code:** |
| **Email address:** | | **English first language:**  Yes No | **Interpreter required:**  Yes No | **Special Needs:** |
| **Other:** |
| **Reason for Referral or please attach detailed letter if needed** | | | | |
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| **Documents to be forwarded along with referral** | | | | |
| * Recent reports of all diagnostics that support or are related to the reason for referral   or  **Ordered Pending**   * Lab results obtained related to this referral   or  **Ordered  Pending**   * All consultant reports and investigational records related to medical diagnosis | | | | |
| **Referring Physician/Nurse Practitioner  Unaffiliated Patient** | | | | |
| **Name:** | | | **Date of Referral:** | |
| **Phone #**  **Email** | | | **License #** | |

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| **OBGYN Office use only: To be completed by Triage Physician** |
| **Referral:**  Accepted  Needs more Information:  Declined: |
| **Triage Grading:**  < 2 weeks  < 6 weeks  6 weeks-3 months  3-6 months  6-12 months |
| **Surgical intervention likely needed:**  Yes  No |
| **Triage Physician signature:**  **Date:** |