# 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:** |