

Patient Name: \_\_\_\_\_

<Patient label>

Referring Physician: \_\_\_\_\_

\_\_\_\_\_  
 Patient Contact Phone #: \_\_\_\_\_  
 \_\_\_\_\_

Referral for:	<input type="checkbox"/> Stress incontinence <input type="checkbox"/> Dyspareunia <input type="checkbox"/> Prolapse <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Chronic non-bacterial prostatitis (Category 3B) <input type="checkbox"/> Bladder Pain Syndrome/Interstitial cystitis	<input type="checkbox"/> Urge incontinence/OAB <input type="checkbox"/> Vaginismus <input type="checkbox"/> Coccydynia <input type="checkbox"/> Vulvodynia
Relevant Medical Info:	<input type="checkbox"/> Client is pregnant <input type="checkbox"/> C-section <input type="checkbox"/> SVD <input type="checkbox"/> Postpartum tearing  <input type="checkbox"/> Abdominal/Pelvic surgery <input type="checkbox"/> Constipation <input type="checkbox"/> Frequent UTI's <input type="checkbox"/> Endometriosis <input type="checkbox"/> Pessary <input type="checkbox"/> IBS	
Medication:	<input type="checkbox"/> NSAIDs <input type="checkbox"/> Contraceptives <input type="checkbox"/> Vaginal estrogen/Moisturizer	<input type="checkbox"/> Hormonal <input type="checkbox"/> Anti-depressants

Additional Info: \_\_\_\_\_  
 \_\_\_\_\_

Client aware of private clinic fees charged per consult.

Client will be phoned to book an appointment.

Thank you for the referral.