# REFERRAL FORM - SEASHELL MEDICAL CENTRE

1927 Ironoak Way, Unit C101, Oakville, ON L6H 0N1
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## Patient Information

Full Name: _____ DOB (YYYY/MM/DD): _____

OHIP #: _____ Phone #: _____

Address: _____

## Reason for Referral (Check all that apply)

■ Routine IUD Insertion
■ Postpartum IUD Insertion
■ IUD Removal/Exchange
■ Pap Smear Only

## Preferred IUD Type (if applicable)

■ Copper (e.g., Mona Lisa)
■ Hormonal (e.g., Mirena, Kyleena, Jaydess)
■ Patient to Decide at Visit
■ IUD Supplied by Patient

## Relevant Medical History (Check all that apply)

■ History of PID
■ Postpartum within 6 weeks
■ Uterine Anomalies/Fibroids
■ Heavy Menstrual Bleeding
■ On Anticoagulants
■ Abnormal Pap Smear in Past
■ Nulliparous
■ Known STI History
■ Breastfeeding
■ Immunocompromised
■ Current or Recent Pregnancy
■ Other: _____

## Pap History

Last Pap Date: _____ Results: _____

■ Never Had Pap Smear ■ Follow-up Recommended

## Allergies (latex, copper, silver, etc.)

_____

## Additional Notes / Referrer Comments

_____

_____

## Attachments Checklist

■ Past Pap Results
■ Ultrasound Reports
■ Medication List
■ STI Results
■ Relevant Consultation Notes

## Referring Physician Information

Name: _____ CPSO#: _____

Clinic Name: _____ Phone: _____ Fax: _____