Baycrest Ambulatory Clinics
Dr. Harold Drutz – Female Pelvic Health Referral Form
3560 Bathurst Street, 1ST floor Hospital Building
Toronto, ON, M6A 2E1
Tel: (416) 785-2500 ext. 2636 Fax: (416) 785-2370

* Required Information > referrals will be returned if incomplete

***Patient's Name** (*first*) _____ (*last*)_____

***Date of Birth** (*dd/mm/yr*) _____

Street Address _____ Apt. #_____ City _____

Province _____ Postal Code _____ Phone # _____

* **Health Card #** ____/____/____ **Version Code** _____

Is patient aware of referral ❑ Yes ❑No

***Primary Contact Person for appointment(s):** _____

***Relationship to client:** _____ **Phone # (daytime)**_____
Phone # (evening) _____

***Is client fluent in English?** ❑ Yes ❑No **If "No", the patient must bring someone with her that can speak both English as well as her language.**

***Does patient have memory issues?** ❑ Yes ❑No **If "Yes", patient must be accompanied by a family member or caregiver**

Please indicate reason for referral: _____
_____
_____

Our clinic also requires the following information, if available:

- Prior pelvic ultrasounds, CT or MRI
- Prior reports from Urogynecology clinic at Mount Sinai Hospital
- Reports from other consultants
- Blood work within the last 6 months
- Urine Tests and Cultures

Name of Family MD *(please print)* OHIP Billing # :	Phone:	Fax:
Name of Referring MD *(please print)* OHIP Billing # :	Phone:	Fax: