London Health Sciences Centre

Continence Clinic Referral Form

PLEASE FAX COMPLETED REFERRAL FORM TO **519-685-8746**.

Missing information may result in a delay of patient's appointment.

Your office will be faxed a notification with the appointment date and time for you to inform the patient.

Patient Name: ____________________ DOB (yyyy/mm/dd): ____________ Age: ______

Health Card Number: ____________________

Address: ______________________________ Postal Code: ____________

Email: ____________________ Phone: ____________ Alt. Phone: ____________

Language: ____________ Interpreter Required (Y/N): ___ Assistive Devices: ____________

PREFERRED OVERSEEING UROGYNAECOLOGIST: ☐ No preference *(assigned based on wait times)*

☐ Dr. Q. Chou	☐ Dr. Y. Leong	☐ Dr. B. MacMillan	☐ Dr. M. Wu
p: 519-646-6343	p: 519-685-8223	p: 519-646-6247	p: 519-685-8484
f: 519-646-6253	f: 519-685-8771	f: 519-646-6039	f: 519-685-8483

REASON FOR REFERRAL (check all that apply)

- ☐ Urinary incontinence
- ☐ Urinary frequency
- ☐ Pelvic organ prolapse – grade 1 or 2
- ☐ Pelvic floor / Kegel exercises
- ☐ Non-surgical education
- ☐ Other: ____________________

CLINICAL EXCLUSION CRITERIA (check all that apply)

- ☐ Previous surgery for prolapse or incontinence
- ☐ Recurrent urinary tract infection
- ☐ Prolapse $\geq$ grade 3 (bulge protrudes beyond vaginal opening)
- ☐ Voiding dysfunction (unable to empty bladder / high post-void residual)

*If any of the above apply, this patient is **NOT** a candidate for the Continence Clinic. An appointment will be arranged with the preferred or assigned overseeing urogynaecologist.*

Referring Physician: ____________________ Billing Number: ____________

Address: ______________________________

____

Phone Number: ____________________ Fax Number: ____________________

For more information about referral criteria, please visit: http://www.lhsc.on.ca/Patients_Families_Visitors/Continenceclinic

If the patient requires further assessment by the physician after their Continence Clinic assessment, this will be arranged through the Continence Clinic. Please do **NOT** send another referral.

FOR CONTINENCE CLINIC OFFICE USE ONLY:

Appointment Date and Time: ____________________