Referral Form for Perimenopausal/Menopausal Assessment (Virtual-only Consultations)

MENOPAUSE AND WOMEN'S HEALTH MD

Date of Referral: _____

Patient Information

Full Name: _____

Date of Birth: _____

PHN/MRN: _____

Address: _____

City: _____

Email Address: _____

Phone Number: _____

Reason(s) for referral (Check all that apply)

Hot flashes/night sweats: ☐

Sleep disturbances: ☐

Vaginal dryness/dyspareunia: ☐

Mood changes: ☐

Cognitive difficulties ("brain fog"): ☐

Menstrual irregularities: ☐

Suspected premature ovarian insufficiency or early menopause: ☐

Urinary symptoms possibly linked to perimenopause/menopause: ☐

Sexual concerns: ☐

Others: _____

_____

Referring Physician Information

Referring Doctor's Name: _____

Clinic Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

PRAC ID: _____

Doctor's Signature: _____

Medical History (Check all that apply):

Hyperlipidemia: ☐ Gallstones: ☐

Breast cancer: ☐ Uterine cancer: ☐

Thyroid disease: ☐ Diabetes: ☐

Hypertension: ☐ Osteoporosis: ☐

Obesity: ☐ Migraines: ☐

Cardiovascular disease: ☐

Previous stroke: ☐

Previous DVT: ☐

Currently smoking: ☐

Most recent BP and date taken:

_____