

REFERRAL FORM (VIRTUAL-ONLY CONSULTATIONS)

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**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:

Weight and BMI: