WOMEN'S MID-LIFE HEALTH PROGRAM REFERRAL: SASKATOON	**Phone: 306-655-7681**
Women's Health Centre, Saskatoon City Hospital	**Fax: 306-655-8176**
701 Queen Street, Saskatoon, SK S7K 0M7	

PATIENT INFORMATION:

Last Name:		First Name:	
Date of Birth:	Address:		
City:	Prov:	PC:	HSN:
Home Phone:	Work Phone:		Cell Phone:

REFERRING PRACTITIONER & CLINIC INFORMATION:

☐ Family Doctor	Name:	
☐ Nurse Practitioner*	Address:	
***associated with Dr. _____for billing purposes**		
☐ Pelvic Floor Physiotherapist		
☐ Naturopath Doctor		
☐ Specialist	Phone:	Fax:

REFERRAL TO:

☐ Next Available Menopause Clinician	☐ Specific Menopause Clinician, list below
Except:	Name:

REASON FOR REFERRAL: Check reason(s)

☐ Vasomotor symptoms (hot flashes, night sweats)	☐ Vulvo-vaginal health
☐ Decreased libido	☐ Premature ovarian insufficency (<40 years old)
☐ Other - (explain)	

PLEASE ATTACH A SUMMARY OF THE PATIENT'S MEDICAL PROFILE INCLUDING MOST RECENT PAP, MAMMOGRAM, FIT, BMD RESULTS, & OTHER RELEVANT TESTS.

PLEASE NOTE: Hormone levels NOT indicated unless premature menopause <40 years old

IF you want this expedited, please explain:

Past Medical History:

Medications:

ALLERGIES:

POOLED REFERRAL INFORMATION: Patients being offered the pooled referral option will receive an acknowledgement letter about this request. Your patient will then receive a step by step process to proceed with their referral.**The physicians within our group are: Dr. Renee Morissette, Dr. Angela Baerwald and Dr. Tracey Guselle.**

Physician Signature:	**Date:**