London Health Sciences Centre

Womens Continence Clinic Referral Form
Registered Nurse Run Clinic

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: ________________

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: ____________________

Referring Physician: ______________________ Billing Number: ____________

Address: ____

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Phone Number: ______________________ Fax Number: ______________________

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

FOR CONTINENCE CLINIC OFFICE USE ONLY:

Appointment Date and Time: ____