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 (MM/DD/YYYY)**:_____
HEALTH CARD NUMBER: _____ **AGE:** _____
ADDRESS: _____
POSTAL CODE: _____ **PHONE:** _____
EMAIL: _____ **ALT NUMBER:** _____
Language:_____ **Interpreter Required: yes no**

REASON FOR REFFERAL

☐ **urinary incontinence**

☐ **urinary frequency**

☐ **pelvic organ prolapse- grade 1 or 2**

☐ **pelvic floor/ kegel exercises**

☐ **non- surgical education**

☐ **Other:**

_____
_____

Has this patient had previous interventions for urinary incontinence?

☐ Yes ☐ No If yes, please identify the interventions _____

☐medication(s) specify: _____

☐ surgery

☐ other specify: _____

Does this patient experience recurrent urinary tract infections?

☐ Yes ☐ No

Does this patient have pelvic organ prolapse?

☐ Yes ☐ No If yes, please identify the type of prolapse _____

☐ cystocele ☐ rectocele - grade, if known _____

☐ uterine prolapse ☐ vaginal prolapse ☐ unknown

Patients Current WT: _____ Patients height: _____

Any Assistive/ Mobility Devices:_____

Referring Physician: _____
Address: _____
_____
_____
Phone Number: _____**Fax number:**_____

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