Referral Form

Please have your physician fill out the following form for you.

Dr. Stephanie Finn
WOMEN'S SEXUAL HEALTH & WELLNESS

Referring physicians please note:

Referral form and any attachments can be faxed to 289-835-3428.

*FHO, FHT patients will need to request they be temporarily de-rostered by their current GP – this is administrative only and does not affect your status with or care provided to you by your current GP.

Patient name

Email Address

Date of Birth (DD/MM/YYYY)

Health Card Number

Date of Referral (DD/MM/YYYY)

Sexual Dysfunction Consult Request

- ☐ Pain Concerns
- ☐ Orgasm Concerns
- ☐ Libido/Desire Concerns
- ☐ Arousal Concerns
- ☐ Sexual Dysfunction Consult Requestz

Please provide a brief description of each concern(s)

Other Consult Request

- ☐ Peri/Menopause Symptom Management (Hormone Therapy/Other)
- ☐ Genitourinary Symptom Management

Please provide a brief description of each concern(s)

Date of Last Mammo (DD/MM/YYYY)

Date of Last BMD (DD/MM/YYYY) (if done)

Referring Physician

Physician Billing Number

Please provide past medical history, surgical history, and meds list