

WOMEN'S & SEXUAL HEALTH

SERVICE REFERRAL FORM

102-3200 Valleyview Dr

Kamloops BC, V2C 4S2

T: 778-362-1582 F: 250-828-8242

Referral Date:	
PATIENT DEMOGRAPHICS	
Last Name:	First Name:
DOB:	PHN #:
Primary Phone Number:	Alternate Phone Number:
SELECT REFERRAL OPTIONS: <ul style="list-style-type: none"> <input type="radio"/> Contraception (Including IUDs and Implants) <input type="radio"/> Cervical Cancer Screening— Please Send Last Screening Results <input type="radio"/> STI / STD Testing and Treatment <input type="radio"/> Therapeutic Abortions <input type="radio"/> Vasectomy Referrals <input type="radio"/> Tubal Ligation Referrals <input type="radio"/> New Breast Lump for Unattached Patients 	
Reason for Referral:	
Relevant History:	Telephone: Fax:
Referring Physician/ Address:	
Signature:	

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