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: ○ Contraception (Including IUDs and Implants) ○ Cervical Cancer Screening– Please Send Last Screening Results ○ STI / STD Testing and Treatment ○ Therapeutic Abortions ○ Vasectomy Referrals ○ Tubal Ligation Referrals ○ New Breast Lump for Unattached Patients	
Reason for Referral:	
Relevant History:	Telephone: Fax:
Referring Physician/ Address:	
Signature:	