TULIP
WOMEN'S HEALTH

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PATIENT INFORMATION

Name: _____

Date of Birth: _____ OHIP: _____

Address: _____

E-mail: _____ Phone: _____

PROCEDURE

Please specify the procedure for which the patient is being referred:

- ☐ IUD Insertion*
- ☐ IUD replacement*
- ☐ IUD removal
- ☐ PAP (HPV) test
- ☐ Implant insertion*
- ☐ Implant replacement*
- ☐ Implant removal
- ☐ Other: _____

IUD & IMPLANT INSERTION/REPLACEMENT

*If the Patient requires IUD/Implant insertion/replacement, complete the following section:

- ☐ Patient is part of FHO/FHN: please indicate so that we can book accordingly to avoid negation
- ☐ Patient requests a specific doctor (Name of doctor: _____)
- ☐ Patient has been appropriately counselled and is ready for insertion.
- ☐ Patient requires counselling and has more questions
- ☐ Patient will bring the IUD/Implant to the appointment.
- ☐ Patient requires PAP (HPV) test at the same time

REFERRING PHYSICIAN

Name of Referring Physician: _____

Billing No.: _____