Men's Health Institute www.MensHealthInstitute.ca

PATIENT REFERRAL FORM

Please fill out all information and include any recent results from labs, images, consults

(You may use any EMR based referral if available)

****WE MUST HAVE THE REFERRING PHYSICIAN'S BILLING NUMBER BEFORE WE ARE ABLE TO BOOK THE PATIENT****

DATE: _____

PATIENT: _____
DOB: _____
HC #: _____
EXP: _____
ADDRESS: _____
_____
PHONE: _____
EMAIL: _____

REF. PHYSICIAN: _____
BILLING# _____
ADDRESS: _____
_____
PHONE: _____
FAX: _____

✓REQUEST FOR CONSULT AND MANAGEMENT
✓ULTRASOUNDS DEEMED AS NECESSARY

◯ Scrotal/Groin Pain	◯ Erectile Dysfunction	◯ Infertility
◯ Pelvic Pain	◯ Premature Ejaculation	◯ Vasectomy
◯ Prostatitis	◯ Testosterone Dysfunction	◯ Vasovasostomy
◯ Prostatitis/BPH	◯ Andropause	◯ Circumcision/Phimosis
◯ General Urology		

SYMPTOMS:

_____
_____

PERTINENT CLINICAL INFORMATION:

_____
_____

CURRENT MEDICATIONS:

_____
_____

Please, kindly ensure that we have the most current information to reach your patient. A current phone number as well as an email address would be great. We communicate with the patients directly and proper contact information ensures our ability to connect with your patient and book him as quickly as possible. As well, attaching any recent images, labs and consults pertaining to the patient's current complaint would be very helpful and would cut down on redundant testing. Thank you!

FAX TO: 416-581-0096

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