Effica Health

# REFERRAL FORM

## Virtual Menopause Clinic

**Fax: 1-855-780-1033**

**Complete all relevant sections. Check all options that apply and attach supporting reports if available.**

## 1 PATIENT INFORMATION

**FULL LEGAL NAME**

**PERSONAL / PROVINCIAL HEALTH NUMBER**

**DATE OF BIRTH** *YYYY-MM-DD*

**PRIMARY PHONE NUMBER**

**EMAIL ADDRESS**

**HOME ADDRESS**

**CITY**

**PROVINCE**

Select...

**POSTAL CODE**

## 2 REFERRING PROVIDER INFORMATION

**REFERRING PROVIDER'S FULL NAME**

**SIGNATURE:**

**CLINIC ADDRESS**

**PHONE NUMBER**

**FAX NUMBER**

**REFERRAL DATE** *YYYY-MM-DD*

**BILLING NUMBER**

**TYPE OF PROVIDER** ☐ Physician ☐ Nurse Practitioner ☐ Other: *Type here*

## 3 REASON FOR REFERRAL

*Check all that apply.*

- ☐ Perimenopause or menopause symptoms (e.g., vasomotor, sleep, cognition / brain fog, etc.)
- ☐ Menopausal hormone therapy (initiation, risk assessment, optimization of current therapy)
- ☐ Non-hormonal options as appropriate (initiation, risk / benefits, optimization of current therapy)
- ☐ Genitourinary syndrome of menopause
- ☐ Sexual-health concerns or low libido
- ☐ Contraception in perimenopause
- ☐ Other concern

**DESCRIBE THE REASON FOR REFERRAL BASED ON THE INFORMATION PROVIDED**

## 4 CLINICAL CONSIDERATIONS: Please select all that apply

*Check all that apply to your patient.*

- ☐ Bleeding disorder
- ☐ Abnormal uterine bleeding
- ☐ Early menopause before age 45
- ☐ Premature ovarian insufficiency
- ☐ Breast cancer history
- ☐ Other cancer history
- ☐ Thrombosis history
- ☐ Stroke or cardiovascular history
- ☐ Active liver disease

If ANY boxes are checked please include details in section 5 and supporting documentation in section 6.

## 5 RELEVANT CLINICAL HISTORY AND ADDITIONAL INFORMATION

*Include pertinent medical history, current medications, menopausal hormone therapy and any other information you would like to share.*

**CLINICAL HISTORY / MEDICATIONS / ALLERGIES/ADDITIONAL INFORMATION**

Attached

## 6 PLEASE ATTACH ALL RELEVANT RESULTS/REPORTS

- ☐ Bloodwork
- ☐ Pelvic ultrasound
- ☐ Endometrial biopsy
- ☐ Other applicable consultations/investigations

**INTERNAL USE** ☐ **Additional Information requested** **Date Reviewed:**

**Please include:**