

PATIENT INFORMATION:		Last Name:	First Name:	
Date of Birth:	Address:			
City:	Prov:	PC:	HSN:	
Home Phone:	Work Phone:	Cell Phone:		

REFERRING PRACTITIONER & CLINIC INFORMATION:

<input type="checkbox"/> Family Doctor	Name:
<input type="checkbox"/> Nurse Practitioner	Address:
<input type="checkbox"/> Specialist	
<input type="checkbox"/> Midwife	Phone:
	Fax:

REFERRAL TO:

<input type="checkbox"/>	<p>Dr. Charles Zhao, BSc, MD, FRCSC OBGYN & Urogynecology 200-3211 Preston Ave South, Saskatoon, SK, S7T 1C9 Phone: 306 244 3080 Fax: 306 244 3017</p>
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REASON FOR REFERRAL: CHECK MOST URGENT REASON AND INCLUDE RELEVANT DOCUMENTATION - DIAGNOSTIC LABS OR IMAGING, PRENATAL RECORDS, CONSULTS, INTERVENTIONS AND REFERRAL LETTER.

ALL OBSTETRICAL REFERRALS REQUIRE EDD:

Prenatal Care	<input type="checkbox"/> Low Risk (Shared Care)	<input type="checkbox"/> Low Risk (Transfer of Obstetrical Care)	
	<input type="checkbox"/> Twins	<input type="checkbox"/> Hypertension	
High Risk Obstetrics	<input type="checkbox"/> Pre-conception Counseling	<input type="checkbox"/> Gestational Diabetes	
	<input type="checkbox"/> Abnormal Prenatal Screen	<input type="checkbox"/> Pre-Existing Diabetes	
	<input type="checkbox"/> Congenital Anomalies	<input type="checkbox"/> HIV Pregnancy	
	<input type="checkbox"/> Previous Obstetrical Anal Sphincter Injury	<input type="checkbox"/> High Risk Other:	
	<input type="checkbox"/> Trial of Labour After Cesarean Section		
	<input type="checkbox"/> Substance Abuse in Pregnancy	<input type="checkbox"/> Intrauterine Growth Restriction/Macrosomia	
Urgent Gynecology	<input type="checkbox"/> Severe Prolapse	<input type="checkbox"/> Infertility (>35 Years of Age)	
	<input type="checkbox"/> Abnormal Ultrasound/Pelvic Mass	<input type="checkbox"/> Menorrhagia with Anemia Hb <100	
	<input type="checkbox"/> Concerning Vulvar/Vaginal/Cervical Lesion	<input type="checkbox"/> Post-Menopausal Bleeding	
	<input type="checkbox"/> Cancer or Highly Suspicious For Cancer	<input type="checkbox"/> Urgent Other:	
Elective Gynecology	<input type="checkbox"/> Contraceptive Advice/Sterilization	<input type="checkbox"/> Pediatric Gynecology	<input type="checkbox"/> Recurrent UTIs
	<input type="checkbox"/> Heavy/Painful/Irregular Periods/Fibroids	<input type="checkbox"/> Pelvic Pain/Dyspareunia	<input type="checkbox"/> Voiding dysfunction
	<input type="checkbox"/> Infertility Age:	<input type="checkbox"/> Urinary Incontinence/Vaginal Prolapse	<input type="checkbox"/> Interstitial Cystitis
	<input type="checkbox"/> Menopausal /Sexual Complaints/Premenstrual Syndrome	<input type="checkbox"/> Vaginal Discharge/Vulvar Complaints	<input type="checkbox"/> Fecal Incontinence
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Lower Urinary Tract Fistula	<input type="checkbox"/> Urethral Divericulum

NOTES: Dr. Zhao is currently NOT accepting patients requiring colposcopy or termination.

POOLED REFERRAL INFORMATION: Patients being offered the pooled referral option will receive the next available appointment with a specialist within this group able to treat the referring condition. Obstetrician/gynecologists who pool referrals but do not share an office use the Referral Management Service at the RQHR to manage their referrals. This service shares de-identified referral information with all the specialists in this group to aid in reducing patient wait times and improving the patient experience.

Questions or feedback can be faxed to 1-855-355-1921 or visit <http://www.health.gov.sk.ca/pooled-referrals-guide>

Physician Signature:	Date:
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