Peninsula Health

REFERRAL
INTRAUTERINE DEVICE
INSERTION

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH ..... Gender .....
Please fill in if no Patient Label available

App.11/12/18 Print Code:14229

PHF055350X

Referral to:

☐ **Dr.Jolyon Ford** for ☐ Hormonal IUD ☐ Non-Hormonal IUD Fax to 9788 1879. **If urgent ring 0466 453 003**

Referral Date:...../...../.....

Patient's Address:.....

.....

.....

Phone Number (H): ..... Phone Number (M): .....

Practice Name: .....

Doctor's Name: ..... Phone No.: .....

Address: ..... Provider No.: .....

Doctor's Signature: ..... Date: ...../...../.....

Reason for Referral / Past History / Current Medications / Allergies

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It is desirable (but not essential) to include recent results.

Checklist: IUD ☐ Client has a script for her IUD

☐ Client knows to bring her IUD

☐ Copies of recent STI screening

☐ Recent CST Result

Interpreter required: ☐ No ☐ Yes - Language .....

Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Is the client aware of the referral and has consent been given including the client's consent to access their medical record?

Clients will be contacted and given an appointment time via a phone call.

It is essential your client brings her IUD with her to the appointment otherwise we may not be able to proceed.

Client's Signature: ..... Print Name: .....

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MR/055350

11/12/18 Print Code:14229 Ref. Link / GP Liaison