

Peninsula Health

**REFERRAL
INTRAUTERINE DEVICE
INSERTION**

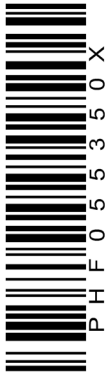
UR NUMBER

SURNAME

GIVEN NAMES

DATE OF BIRTH Gender

Please fill in if no Patient Label available App.11/12/18 Print Code:14229



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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

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:

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

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MR/055350