Sexual Health Program

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NORFOLK
FAMILY HEALTH TEAM

Your well-being is our Primary care

Referral Form:

Patient Label:

Date of Referral:

____

Please ensure that the following information is included for your patient:

- Full Name, Date of Birth
- Address, Phone Number
- Health Card Number

Reason for Referral:

☐ PAP test
☐ Contraception – Low-cost birth control available
☐ STI testing and management

☐ **Confirm OK to leave a message at the phone # listed above**

Current Medications: ____

Allergies: ____

Other Notes: ____

Referring Health Care Provider Name: ____

Health Care Provider's Phone #: ____

Health Care Provider's Fax #: ____

Please attach any relevant health records (ie. Recent labs, previous PAP's etc)
Thank you. We will contact your patient to book an appointment.

Administration Only
Eligible for Program? ____________________ Appointment Booked? ___________________