CALEO HEALTH

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IUD CONSULTATION & SMOKING/TOBACCO CESSATION REFERRAL FORM

Date:

Patient Information:

(Place label here)

Name: _____ Home#: _____

Address: _____ Cell#: _____

Provincial Health Number (PHN): _____

REFERRAL TYPE (CHECK APPROPRIATE REFERRAL):

Please attach all relevant labs and diagnostic reports

☐ FOR INTRAUTERINE DEVICE (IUD)

- ☐ CONSULTATION
- ☐ INSERTION
- ☐ REMOVAL

☐ SMOKING / TOBACCO CESSATION

Referring Physician's Information:

(Place stamp here)

Name: _____ Tel#: _____

Address: _____ Fax#: _____

Practitioner's ID: _____ *Copy to:* _____

PLEASE SEND REFERRAL VIA FAX TO (403) 984-5445

For more information please call (403) 547-9135