

New Patient     Re-Referral

Date: \_\_\_\_\_

Patient Name: _____	Pronouns: _____
Address: _____	Best Phone Number: _____
Date of Birth: _____ (DD/MM/YYYY)	PHN: _____
**Email (Required)**: _____	<input type="checkbox"/> Consent to contact by email
Fluent English <input type="checkbox"/> Y <input type="checkbox"/> N    Interpreter Required <input type="checkbox"/> Y <input type="checkbox"/> N    Language _____    Identify as Indigenous <input type="checkbox"/> Y <input type="checkbox"/> N	

**Referring Care Provider**

Name: \_\_\_\_\_  
 GP     Specialist     Other \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 MSP#: \_\_\_\_\_

**Primary Care Provider (if different from referring)**

Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 MSP#: \_\_\_\_\_

**Advice call for community gynecologists** (call will be scheduled within one week)

*Please note: this is for patients not being referred to the clinic*

Who agrees to continue care?     Primary Care Provider     Referring Care Provider

**Inclusion Criteria**

**PLEASE SELECT REASON FOR REFERRAL:**

- Advanced Endometriosis** (ovarian endometrioma, deep endometriosis, extra-pelvic endometriosis)
  - Surgical diagnosis                      OR                       Imaging/clinical diagnosis

**Please attach ALL relevant surgical and imaging reports**

- Persistent Pelvic Pain** unresponsive to first line management (please see *info sheet*)  
 Patient must have been assessed & treated by a Gynecologist in the **last 3 years** for this problem and **consult letter must be included with referral**
  - Gynecological letter attached

**Note:** The CPP/endometriosis clinic has a standardized approach and is program-based. Your patient will be scheduled with the next available physician to minimize waiting time. Our physicians are Dr. Catherine Allaire, Dr. Mohamed Bedaiwy, Dr. Caroline Lee, Dr. Tinya Lin, Dr. Christina Williams, Dr. Paul Yong, and our clinical fellow.

**Other information (for triage purposes)**

- Patient wants surgery \_\_\_\_\_
- Urgent Referral – Provide details \_\_\_\_\_

**Exclusion Criteria**

- |   |   |
|---|---|
| Adolescents (age < 16)                                  | Age > 55                                    |
| Vestibulitis/vulvodynia/introital dyspareunia only      | Post-menopausal (surgical or natural)       |
| Urology-gynecology (mesh, tape complications, prolapse) | Myofascial/back pain only                   |
| Currently Pregnant/Postpartum < 6 months                | Neuropathic pain only                       |
| Unstable or Untreated Psychiatric issues                | Untreated/ongoing substance abuse/addiction |
| Lives outside BC  | No BC MSP                                   |

\*\*\*\*\* *Clinic does not assume opioid prescribing. There are no addiction services in our clinic* \*\*\*\*\*

**\*\*Patients will not be triaged until all information regarding previous investigations is received.  
 Patients accepted to the clinic will be contacted directly by our office\*\***