BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

MENOPAUSE + MIDLIFE HEALTH PROGRAMS

Complex Menopause Clinic
B4-4500 Oak St.
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REFERRAL FORM - Complex Menopause Clinic

Date of Referral: _____

New Patient ☐

Patient Name:_____ PHN (Personal Health Number):_____

Address: _____ Primary Phone Number: _____
Date of Birth (DD/MM/YYYY):_____
Email:_____ ☐ Consent to contact by email

Referring Provider: _____MSP#_____ ☐ Specialist ☐ GP ☐ Other_____
Primary Care Provider (if different from referring) _____
Who agrees to continue care? ☐ Referring Provider ☐Primary Care Provider
Does the patient identify as Indigenous (First Nations, Metis, Inuit)? ☐ Yes ☐ No
Is an Interpreter required? ☐ Yes ☐ No Language Required:_____
Does the patient prefer to attend the appointment: ☐ Virtual ☐ In Person ☐ Either

Inclusion Criteria

Patient had premature menopause/POI < age 40. Date of last menstrual period (MM/DD/YYYY):_____ Most recent FSH result and date (required):_____	☐
Patient has complete contraindications to hormone therapy, limiting management options. Please check the appropriate box below and provide supporting documentation (required): ☐ Personal history of estrogen-dependent cancers (eg. Breast, Endometrial, Ovarian) ☐ Coronary artery disease ☐ Active or previous personal history of stroke, TIA, MI, or VTE ☐ Acute liver disease (not including fatty liver disease) ☐ Inherited high risk of VTE (eg. Thrombophilia) ☐ Systemic lupus erythematosus (SLE) with anti-phospholipid antibodies	☐
Increased cancer risk: Patient is a carrier of Hereditary Cancer Syndrome with increased risk of breast or gynecologic cancer(s) that has been confirmed through genetic testing or is at high risk for cancer for other reasons, established with a risk assessment tool: Name of condition/gene mutation: _____ Copy of reports/supporting evidence included (required): *High-risk genes associated with hereditary breast and/or ovarian cancers include the BRCA1 or BRCA2 gene mutation, as well as PALB2, TP53, PTEN, STK11, and CDH1. Please see this document for more information on who is considered at high risk: HCP_GuidelinesManuals_HBOC.pdf* Risk assessment tool used and results: _____ ☐ Lifetime risk >20-25 % using IBIS or BCRAT models ☐ BCRAT 5-year risk >1.7% ☐ IBIS 10-year risk ≥ 5 %	☐

Patient has a spinal cord injury and is experiencing menopausal symptoms. Level of injury: _____ Mobility aids used and frequency: _____	☐
Patient has HIV and is experiencing menopausal symptoms.	☐
Patient is a cancer survivor whose therapy has affected ovarian function. Type of cancer: _____ Type of treatment(s) and duration: _____	☐
Patient is currently experiencing systemic menopausal symptoms (e.g., hot flushes, night sweats) that have not responded to usual management. Please specify which symptoms and which treatments have been tried below (required): Symptoms: ☐ Changes to periods ☐ Hot flashes or night sweats ☐ Vaginal dryness or pain/dyspareunia ☐ Bladder issues, incontinence ☐ Sleep disturbance ☐ Mood disturbance ☐ Irritability/anxiety ☐ Other:_____ Treatments previously tried: ☐ Oral contraceptive pills ☐ Progestin-only treatments ☐ Systemic estrogen (with or without progestin) therapy, Duavive, or Tibella ☐ SSRI/SNRI (i.e. Venlaxafine) ☐ Gabapentin ☐ Oxybutynin ☐ Fezolinetant/Elinzanetant	☐
Patient is experiencing Genitourinary Syndrome of Menopause (GSM) that has not responded to usual management, without vulvar dystrophy. Indicate all treatments that have been tried (required): ☐ Vulvar moisturizers ☐ Vaginal moisturizers ☐ Lubricants ☐ Vaginal estrogen ☐ Systemic hormone therapy	☐
Other Indication: ***(May include patients with multiple comorbidities. Please explain in detail below and provide relevant documentation).***	☐

Please include the following: diagnostic and lab tests below, ***if not available in CST:***	Yes	N/A
Previous consultations/clinic notes regarding menopausal concerns or relevant issues.	☐	☐
Pap/HPV test report	☐	☐
Mammography report	☐	☐
Bone Mineral Density scan	☐	☐
FIT test/Colonoscopy report	☐	☐

Exclusion Criteria

- Patient currently not a BC resident
- Patient was assigned male at birth
- Patient does not have a care provider (MD or NP) for ongoing follow-up care.
- Post-menopausal bleeding/abnormal uterine bleeding not yet assessed (refer to community gynecologist).
- Patient has already been seen in the CMC and has been discharged. In these cases, we may provide provider-to-provider consultations. Please contact the clinic.
- Patient does not consent to having their visit/consult documented on EMR/CST Cerner
- ***Isolated complaints including but not limited to urinary incontinence, low libido, midlife weight gain, vulvar issues, or mental health issues.***
- This is an urgent request – please refer to ER or UC as appropriate.

Violence screening

Does this patient have a history of aggression?	Yes ☐	No ☐
If yes:	Verbal ☐	Physical ☐

Please provide a brief description of the history of verbal and/or physical aggression incidents, outcomes and date of last occurrence (e.g. throwing objects, hitting someone, yelling).

_____

Effective Intervention(s)

_____