HART FAMILY MEDICAL
AND IUD CLINIC

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Referral Form

[Please affix patient label]		Referring MD:
Patient Name:	Date of birth:	PracID:
Phone number:	AHC #:	Fax:
Address:		

Date of referral: **Preferred physician**:

Referral reason:

☐ IUD insertion ☐ Endometrial Biopsy

*Please attach any relevant imaging (U/S pelvis not necessary but helpful)

Dr. Hart is now seeing patients for subdermal implant contraceptive insertion.
Please check box below if your patient is interested:

☐ Etonogestrel – extended release subdermal implant (*Nexplanon*)

Patient BMI: ☐ <35 ☐ >35

Patient Parity: G___ P___

We will contact the patient directly within 7 days for booking.
After consultation, the referring physician will be provided with a consult letter.

Fax completed form to: **(403) 452 - 7311**