

Self-Referral Patient Intake Form

Please complete all fields below to help us serve you better.

Personal Information

First Name	
Last Name	
Preferred Name (if different from first name)	
Pronouns	
Date of Birth (YYYY-MM-DD)	
OHIP Number including version code	
Mailing Address	
Phone Number	
Email Address	

Reason for Referral

Please check one or both

Cervical cancer (HPV) screening (Pap test) <input type="checkbox"/>	Contraception consultation (including IUD/Nexplanon insertion or removal) <input type="checkbox"/>
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Please Note:

- **When self-referring to our clinic, you will be placed in a queue and your appointment will be booked based on physician availability.**
- If you have a family physician you will require a referral from them. Please contact their office for a referral and do not complete this form.
- If you are being seen for IUD insertion, you may have an initial appointment to discuss pain management prior to booking the insertion if you wish.
- You may still have cervical cancer screening done if you are actively menstruating.
- **You will only be seen for the above issue; any further issues will require a physician referral.**