RISE
WOMEN'S HEALTH

Healthcare Provider Referral

Thank you for referring your patient to Rise Women's Health.

This form is intended for healthcare professionals referring patients for consultation, procedures, or shared ongoing management. Please attach any relevant records to assist with triage and appointment planning.

Referring Provider

Name: _____

Profession: ☐ Family Physician ☐ Nurse Practitioner ☐ Other: _____

Clinic Address:_____

Phone: _____

Fax: _____

Email: _____

Is the referring provider also the patient's primary healthcare provider?

- ☐ Yes
- ☐ No

If known, please specify the patient's primary healthcare provider:

Name: _____

Profession: ☐ Family Physician ☐ Nurse Practitioner ☐ Other: _____

Clinic (optional): _____

- ☐ The patient does not have a primary care provider

Requested Service:

- ☐ Consultation with recommendations to the referring provider
- ☐ Consultation with shared ongoing management
- ☐ Ongoing management by Rise Women's Health (where appropriate)
- ☐ Procedure only
- ☐ Procedure with follow-up
- ☐ Unsure—please advise

Patient Information:

Full name:_____

Preferred name:_____

Date of birth:_____

Health card #:_____

Sex assigned at birth:

- ☐ Female
- ☐ Male

Gender identity (optional): _____

Preferred pronouns (optional):_____

Address:_____

_____

City:_____

Province:_____

Phone:_____

Patient's email (if available):_____

Is the patient pregnant or breastfeeding/chestfeeding?_____

If pregnant, what is the estimated GA or due date?_____

Clinical Question / Referral Details

Please include the reason for referral, relevant history, previous treatments, and your specific clinical question.

_____
_____
_____
_____
_____
_____

Reason for referral, please check all that apply (optional):

Menstrual & Menopause

- ☐ Menopause / perimenopause
- ☐ Premature or treatment-induced menopause
- ☐ Hormone therapy (HRT)
- ☐ Abnormal Uterine Bleeding
- ☐ Menorrhagia
- ☐ Dysmenorrhea
- ☐ PMS / PMDD
- ☐ Post menopausal bleeding
- ☐ Amenorrhea / oligomenorrhea
- ☐ Menstrual suppression
- ☐ Menstrual related hormonal concern (e.g. acne, weight gain, migraines, other)

Specialized Care

- ☐ Gender-affirming care
- ☐ POTS / dysautonomia
- ☐ Inappropriate sinus tachycardia
- ☐ Long Covid
- ☐ Hypermobility (hEDS/HSD)
- ☐ Weight management & metabolic health
- ☐ Chronic migraines

Pelvic & Gynecologic

- ☐ Pelvic pain
- ☐ Endometriosis
- ☐ PMOS (formerly PCOS)
- ☐ Genitourinary syndrome of menopause (GSM)
- ☐ Recurrent urinary tract infections
- ☐ Recurrent vulvovaginitis
- ☐ Dyspareunia
- ☐ Vulvar disorders
- ☐ Contraception
- ☐ Sexual health

Pregnancy

- ☐ Pregnancy options counselling
- ☐ Medical abortion
- ☐ Early pregnancy assessment

Other

- ☐ Complex women's health consultation
- ☐ Second opinion:_____
- ☐ Other:_____

Procedures (Peterborough in-person clinic beginning October 2026)

- ☐ IUD insertion/removal
- ☐ Nexplanon insertion/removal
- ☐ Endometrial biopsy
- ☐ Vulvar biopsy
- ☐ Cervical polyp removal/biopsy
- ☐ Skin biopsy
- ☐ Cyst removal
- ☐ Other procedure _____

** Please attach any relevant consultation notes, laboratory results, imaging reports, pathology reports, medication list, and other records that may assist with triage.**

Has the patient been informed that Rise Women's Health is a privately funded clinic and that assessment and treatment fees may apply (required)?

- ☐ Yes
- ☐ No

Requested Priority

- ☐ Routine
- ☐ Urgent (please indicate reason)

Reason:_____
_____

Has the patient consented to this referral and the sharing of relevant medical information with Rise Women's Health? *(required)*

- ☐ Yes
- ☐ No

Please note: Referral acceptance is based on clinical scope, capacity, and service availability. Receipt of a referral does not guarantee acceptance or appointment.

Contact Us
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