Centre for Pelvic Floor Competence

Pessary Clinic Referral Form

Fax 604-806-8521

Patient Name:_____
PHN:_____
DOB: _____
Patient Address:_____
_____
Patient Phone: _____
Referring Doctor: _____
Referring Doctor billing number: _____
Family Physician: _____

Referral Date: _____

Referral Indication:

Prolapse Urinary incontinence Both

Bladder symptoms:

Stress urinary incontinence Urge urinary incontinence
Obstructive Frequency/urgency

Previous pessaries:

Year of Fitting:_____ Name of pessary: _____ Size of pessary: _____

Reasons for previous pessary failure (if applicable): _____

Current pessary: Yes No

Type: _____

Care of pessary currently done by:

Physician Nurse Patient N/A

Please complete this form and fax it to The Centre for Pelvic Floor at 604-806-8521