

AH: Sam Leung JPM '10
NCA

68390



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
Obstructive

Urge urinary incontinence
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

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