FAX: (250) 940 6011
1280 Fairfield Rd
info@womenmd.ca

PHYSICIAN REFERRAL FORM

Dr.V.A.Gooderham MD, CCFP, BHSCPT, SEM, NCMP and Associates

Date:	
PATIENT INFORMATION *(affix label or complete)* Name: PHN: DOB: Address: Home phone: Alternate phone: Email **mandatory* :	**REFERRING PHYSICIAN** *(affix label or complete)* Name: MSP: Address: Phone: Fax: If applicable, Walk In Clinic Name: Family physician: (if not referring MD)
Reason for referral: *(include diagnosis)*	**Medication**

☐ IUD Clinic ☐ Menopause

☐ Sexual Medicine ☐ Pelvic Floor Physiotherapy
(Urinary Incontinence, Chronic Pelvic Pain, Pre and Post Partum)

☐ Lifestyle Medicine CHANGE Canadian Health Advanced by Nutrition and Graded Exercise ☐ Exercise Medicine/ Movement Therapy
(Physiotherapy/ Yoga therapy)

*Refer to Eligibility Criteria

☐ Mental Wellness and Resilience

Mindfulness Based Stress Reduction (MBSR) Cognitive Behavioural Therapy (CBT)
Mindfulness Based Cognitive Therapy (MBCT) CBT for Insomnia (CBTi)
Mindfulness and menopause Registered Clinical Counsellor
Self-compassion
Mindful Eating **Please complete and attach the Mental Health & Resilience Eligibility Criteria Form*

☐ Wellness thorough the Life Span *(please specify)*

☐ Osteoporosis classes ☐ Menopause
☐ Post-mastectomy classes

MD Signature _____