womenMD

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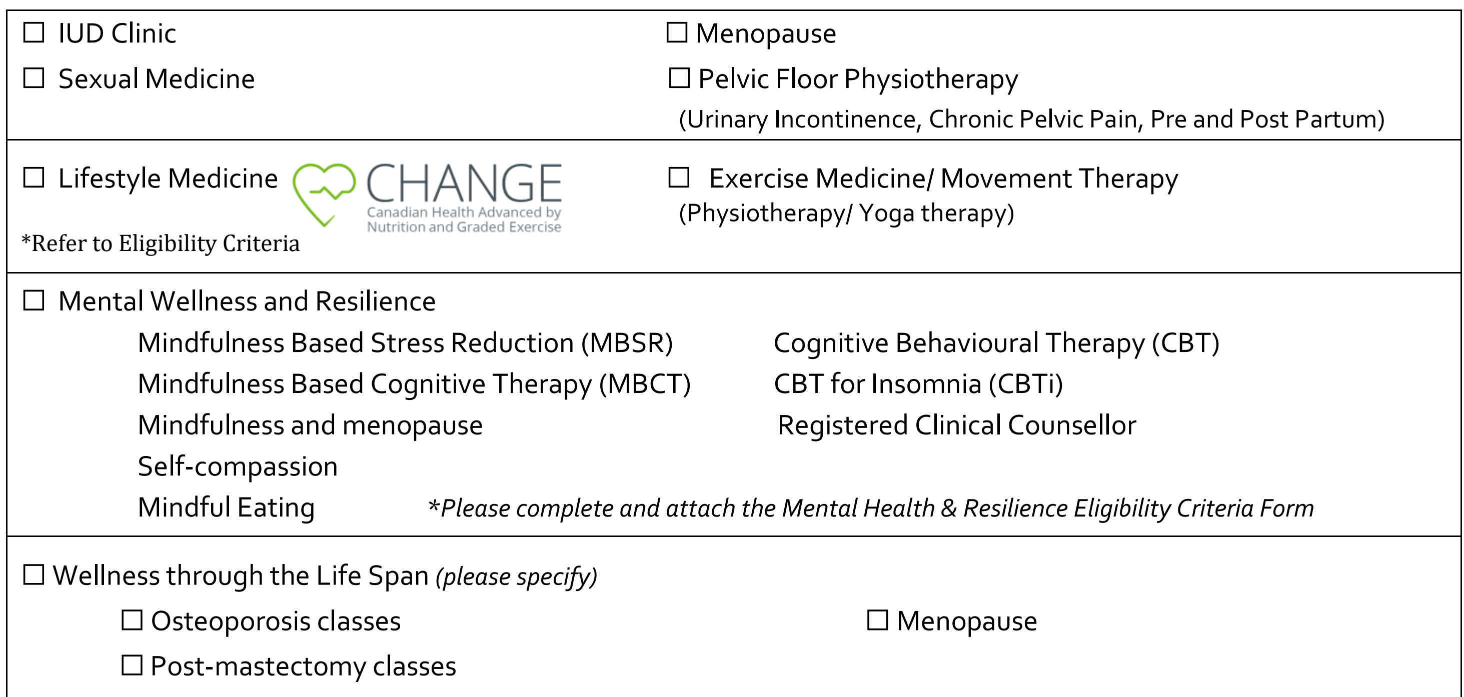
1280 Fairfield Rd
info@womenmd.ca

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 PRACTITIONER** *(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(s)**



☐ IUD Clinic

☐ Sexual Medicine

☐ Menopause

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

☐ Lifestyle Medicine CHANGE Canadian Health Advanced by Nutrition and Graded Exercise
*Refer to Eligibility Criteria

☐ Exercise Medicine/ Movement Therapy
(Physiotherapy/ Yoga therapy)

☐ Mental Wellness and Resilience

Mindfulness Based Stress Reduction (MBSR)
Mindfulness Based Cognitive Therapy (MBCT)
Mindfulness and menopause
Self-compassion
Mindful Eating

Cognitive Behavioural Therapy (CBT)
CBT for Insomnia (CBTi)
Registered Clinical Counsellor

**Please complete and attach the Mental Health & Resilience Eligibility Criteria Form*

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

☐ Osteoporosis classes
☐ Post-mastectomy classes
☐ Menopause

MD Signature ____