JPOSC Pelvic Pain, Endometriosis and Sexual Pain clinic
9740 140St
Surrey, BC V3T 0G9
Phone:(604) 582-4587
Fax:(604) 582-4591

REFERRAL FORM Date of referral mm/dd/y____________ Re-referral? ☐ Yes ☐ No

PATIENT DETAILS: Surname:	____________________ ______________	First Name:	____________________ __________
DOB (mm/dd/yy):	____________________ Age__________	PHN:	____________________ __________
Address:	____________________ ______________	City/Town:	____________________ __________
Province:	____________________ ______________	Postal code:	____________________ __________
Phone: Hm/Cell:	____________________ ______________	Work/Other:	____________________ __________
Does patient speak, read, and understand English?	☐ Yes ☐ No	Interpreter requested?	☐ Yes ☐ No

REFERRALFOR: Chronic Pelvic Pain/ Endometriosis ❑ Chronic Pelvic Pain ❑ Endometriosis	Referral to: ❑ Dr Mui, Justin ❑ Dr Storness-Bliss, Claudine ❑ Any of the physicians listed above
Sexual pain ❑ Vulvodynia ❑ Vestibulodynia ❑ Other	Referral to: ❑ Dr Ariela Rozenek
COMMENTS: ____ ____ ____ ____	

MEDICAL RECORDS (If previous work-up has been done, attach copies of relevant information, including laboratory and operative reports)

PATIENT QUESTIONNAIRE MUST BE ATTACHED

REFERRING PHYSICIAN: Physician name:	____________________ ____________	Billing #:	____________________ __________________
Phone:	____________________ ____________	Fax:	____________________ __________________

Thank you for referring your patient to the JPOSC Pelvic pain, Endometriosis and Sexual Pain Clinic
We will contact the patient with appointment details.