MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Frances Bloomberg Centre for Women's and Infants' Health

Women's Unit
700 University Ave., 8th Floor South
Toronto, ON M5G 1Z5
Phone: (416) 586-4800 ext. 4621 Fax: (416) 586-5941

Referral Form

Colposcopy Clinic

Please complete ALL of the following information and fax to 416-586-5941. We will contact your office with the appointment after all required information is completed.

Patient Information

Name: _____ Phone: _____
Last Name *First Name*

Date of Birth: _____ Health Card No. _____
(YYYY-MM-DD)

Does patient need a translator? ❑ No ❑ Yes If yes, specify language _____

Relevant medical history:

Please attach the 2 most recent Pap smear results

Referring Physician

Name: _____ Phone: _____
Last Name *First Name*

Address: _____ Fax: _____

Email: _____ OHIP Billing No. _____

Colposcopy Clinic Use Only

Referral Accepted: ❑ No ❑ Yes Appointment date/time: _____