

REGINA PELVIC FLOOR PATHWAY CLINIC

Primary Provider Assessment & Referral Form

fax: 306-766-7551
phone: 306- 766-0401

REFERRING PHYSICIAN

Date: _____

STAMP

Signature: _____

PATIENT INFORMATION

Surname: _____		First Name: _____
Address: _____		
DOB: _____	Age: _____	HSN: _____
Phone:(h) _____		(w) _____
(c) _____		

DIAGNOSIS: (check all that apply)

- Urge incontinence Stress incontinence Pelvic organ prolapse

REASON FOR REFERRAL TO CLINIC:

General assessment and treatment navigation

I understand that my patient will be assessed by qualified clinic personnel who will provide education and decision support and initiate treatment as selected by patient.

My patient has an interest in:

- ___ Education/lifestyle change
___ Pelvic floor physical therapy
___ Pessary fitting

TREATMENTS ATTEMPTED:

- Lifestyle modification (weight loss, caffeine reduction) Pessary
 Home exercise program (Kegels) Medications _____
 Pelvic floor physical therapy Surgery

PERTINENT MEDICAL/SURGICAL HISTORY: Please attach all relevant documents

List of operations:

List of medications:

General comments:

INVESTIGATIONS: Please attach all relevant documents

NOTE: The Pelvic Floor Pathway Clinic assesses and treats patients with persistent, uncomplicated incontinence and prolapse. **If red flags are present, please refer directly to appropriate specialist.** Red flags indicating specialist assessment include hematuria, intractable UTIs, elevated post-residual volume, pelvic mass, possible fistula, possible neurologic lesion, cognitive impairment.

SURGICAL REFERRAL: If surgical care is selected, please direct my patient as follows:

- Back to me
 Regina only: pooled referrals – send to the next available surgeon
except Dr. _____
 To a specific surgeon, Dr. _____

CLINIC RESPONSE

Appointment date:

Patient completed assessment: yes no