

DATE: \_\_\_\_\_

## PATIENT INFORMATION

Full Name: \_\_\_\_\_

PHN: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth (MM/DD/YY): \_\_\_\_\_

Current Age: \_\_\_\_\_

Phone Number - Cell: \_\_\_\_\_

Home/Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

## REFERRING PROVIDER

Provider Full Name: \_\_\_\_\_

PRACID: \_\_\_\_\_

Clinic Name/Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

## CONSULTATION REQUEST

Please be specific and select all that apply

- Initiation/Optimization of Menopausal Hormone Therapy (MHT)
- MHT Risk Assessment (Breast/ Heart/ Bone)
- Genito-Urinary Syndrome of Menopause (GSM)
- Sexual Health Concerns/ Low Libido
- Pelvic Health (Bladder/ Bowel/ Prolapse)
- Midlife Mental Health - Depression, Anxiety, ADHD
- Healthy Aging / Sarcopenia / Strength Training

## URGENT/SEMI-URGENT REFERRALS INCLUDE

Please check off if relevant

- Breast cancer survivor
- Oncology treatment induced menopause
- Premature Ovarian Insufficiency (<40 yo)
- Early Menopause (40-45 yo)
- Thrombosis History
- Stroke/CAD History

## OTHER RELEVANT INFORMATION

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\_\_\_\_\_



## THANK YOU FOR YOUR REFERRAL

*Milestone Menopause Centre of Southern Alberta*

Glendeer Professional Building - #160, 1035 - 64th Avenue SE Calgary T2H 2J7

Phone: 587-582-6586 Please FAX referrals to: 403-538-6586

Email: [myhealth@milestonemenopausecentre.ca](mailto:myhealth@milestonemenopausecentre.ca)