BeWell Medical Clinic

Dr. Nazanin Baradaran M.D., C.C.F.P.

IUD & PAP Referral Form

Date: _____

Patient Information:

(place label here)

Name: _____ Date of Birth: _____

PHN #: _____ Cell/Phone#: _____

Address: _____

Thank you for referring your patient for *(check all that apply):*

IUD/IUS:

☐ Consultation ☐ Insertion*

☐ Placement Check ☐ Removal

OR

☐ PAP test

* For insertion only visits, please provide patients with IUD prescription and ask them to bring the device to the appointment.

Reason for IUC Insertion:

☐ Contraception (Incl. Emergency Contraception)

☐ Menorrhagia / Dysmenorrhea / Endometriosis

Referring Physician Information:

(place stamp here)

Name: _____ MSP Billing #: _____

Phone #: _____ Fax #: _____

Address: _____

Signature: _____

Please FAX referrals to (**604) 770 0165**

BeWell Medical Clinic
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