JPOCSC Maternity Clinics: POSTPARTUM CONTRACEPTION AND IUD CLINIC REFERRAL

**Reason for Referral:**
- [ ] Postpartum contraception and intrauterine device counseling
- [ ] IUD insertion only: Insertions include PAP (if applicable) and STI screening

**Delivery Information:**
- [ ] G [ ] P [ ] T [ ] A [ ] L
- Date: _________________
- Type of Birth: _________________

**Patient Medical History:**
- [ ] Active malignancy
- [ ] Unexplained vaginal bleeding
- [ ] History of breast cancer
- [ ] Seizure disorder on anticonvulsants
- [ ] Active pelvic inflammatory Disease
- [ ] Known anatomic abnormalities
- [ ] Current breast disease
- [ ] Fibroids
- [ ] History of thromboembolic event
- [ ] Migraine headaches
- [ ] Hypertension
- [ ] Other (please specify): _________________

**Allergies:**
- _________________
- _________________

**Current Medications:**
- _________________
- _________________

**Please ensure the following are attached to this referral form:**
- [ ] Antenatal records (if available)
- [ ] Most recent PAP report
- [ ] Labour and delivery records

**Family Physician (if different from referring provider)**
- Name: __________________________
- MSP #: __________________________
- Phone: __________________________ Fax: __________________________
- [ ] Patient has no GP/NP

**Referring Health Care Provider:**
- Name: __________________________
- MSP #: __________________________
- Phone: __________________________ Fax: __________________________
- [ ] GP
- [ ] Ob/Gyne
- [ ] NP
- [ ] MW
- [ ] Other

**Referring Practitioner Signature:** __________________________

**Date of Referral:** __________________________