Women's Clinic - Vancouver General Hospital
part of the Vancouver Coastal Health Authority

MULTIDISCIPLINARY VULVODYNIA PROGRAM REFERRAL FORM

PCIS LABEL

THIS SPACE FOR WOMEN'S CLINIC USE ONLY

VGH Women's Clinic
Gordon and Leslie Diamond Health Care Centre
6th Floor - 2775 Laurel Street, Vancouver

PATIENT DETAILS

Name:	Address:
Date of Birth:	Telephone Home: Work:
PHN #:	Referring MD Name: Billing #:
Cytology Lab ID Number:	Referring MD Telephone: Fax:

PATIENT HISTORY

What is the reason for referral?

Has the patient been seen by another provider for this issue?
Yes ☐ No ☐ If yes, by whom? _____
Please attach relevant consult notes

Describe any recent or previous genital pain:

Does your patient experience pain with intercourse? Yes ☐ No ☐
Does your patient have a complete inability to have intercourse? Yes ☐ No ☐
Does your patient experience daily vulvar discomfort Yes ☐ No ☐
☐ No significant history

Additional Medical History:

☐ No significant history

Surgical history:

☐ No significant history

Psychiatric history:

☐ No significant history

Triage Information - For Women's Clinic Use Only

☐ ACCEPTED ☐ REJECTED ☐ MORE INFORMATION REQUIRED
Triaged by: _____ Date: _____

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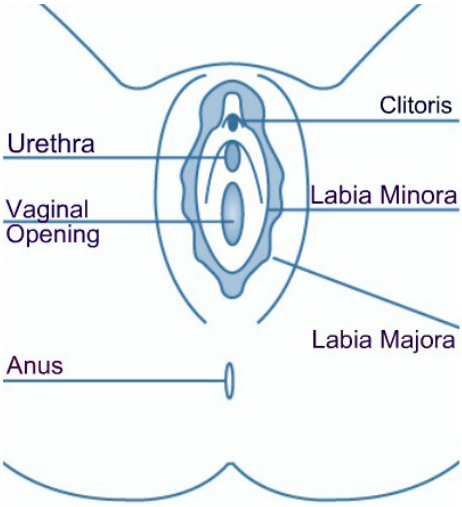
PATIENT HISTORY CONTINUED

Did you perform a pelvic exam? Yes ☐ No ☐

Did you perform a speculum exam? Yes ☐ No ☐

Vulvar Examination:

Please describe



Mark the location of pain with Q-Tip test on this diagram

Medications:

Is this patient on hormone therapy?

Yes ☐ No ☐

Allergies:

☐ None

Other relevant information:

REFERRAL CRITERIA

Is this patient FLUENT in English? Yes ☐ No ☐

Can this patient commit to attending all 12 MVP sessions at Vancouver General Hospital? Yes ☐ No ☐

Do you agree to provide ongoing care? Yes ☐ No ☐

PLEASE COMPLETE THIS FORM IN FULL & FAX TO 604-875-5807

NOTE: FAILURE TO COMPLETE THIS FORM IN FULL WILL RESULT IN YOUR REFERRAL BEING REJECTED

Your office will be informed via fax if this patient is accepted for an assessment with the MVP.