Dr. Rolla Ibrahim
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PATIENT REFERRAL FORM

PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____

City: _____ Postal Code: _____ Phone: _____

Health Card #: _____ Version Code: _____

SERVICES REQUESTED (PLEASE CHECK ALL THAT APPLY)

☐ IUD insertion — Copper IUD	☐ Nexplanon insertion
☐ IUD insertion — Kyleena, Mirena	☐ Nexplanon removal
☐ IUD removal	☐ Contraception counselling and management
☐ Pap	☐ Hormone Replacement Therapy (HRT)

Please note: *Do not prescribe the contraceptive device in advance. Dr. Ibrahim completes a full consultation prior to prescribing and arranging insertion.*

CLINICAL HISTORY

Please include relevant clinical history, current medications, allergies, and any other information helpful to this consultation.

REFERRING PROVIDER

Name: _____ Billing No.: _____

Address: _____

Phone: _____ Fax: _____

☐ **Check here if FHO/FHT** *(to avoid negation)*