Norfolk Prenatal and Newborn Health Program
105 Main Street
Delhi, ON N4B 2L8
Phone: 519-582-2323 ext. 282
Fax: 519-582-1513

NORFOLK FAMILY HEALTH TEAM
Your well-being is our Primary care

Referral Form – IUC/Contraceptive Counselling/PAP tests

_____

First Name Last Name Date

_____

Address Unit City Postal Code

_____

DOB Health Card Number VC Phone #

☐ **Confirm OK to leave a message at the phone # listed above**

Reason for Referral

☐ **PAP test**

- ☐ Meets current screening criteria: age ≥ 21 years old and due for screening
- ☐ No primary care provider

☐ **Contraceptive Counselling/STI Screening**

☐ **IUC Insertion/Removal**

- ☐ Meets criteria age ≥16 years old
- ☐ Nulliparous OR ☐ Parous
- ☐ Has IUC Rx (type:_____) Note: Mirena and Kyleena are covered by ODSP, OW and OHIP+
- ☐ Requires IUC counselling and Rx

Current Medications: _____
Allergies: _____
Other Notes:
_____
_____
_____

Referring Health Care Provider Name: _____
Health Care Provider's Phone #: _____
Health Care Provider's Fax #: _____

Please attach any relevant health records (ie. Recent labs, previous PAP's etc)
Thank you. We will contact your patient to book an appointment.

Administration Only
Eligible for Program? _____ Appointment Booked? _____