SASKATOON PELVIC FLOOR PATHWAY CLINIC
Primary Provider Assessment & Referral Form

fax: 306-655-7918
phone: 306-655-7901

REFERRING PHYSICIAN

Date: _____

STAMP

Signature: _____

PATIENT INFORMATION

Surname:	First Name:
Address:	
DOB: Age:	HSN:
Phone:(h) (c)	(w)

DIAGNOSIS: (check all that apply)

☐ Urge incontinence ☐ Stress incontinence ☐ Pelvic organ prolapse

REASON FOR REFERRAL TO CLINIC:

☐ **General assessment and treatment navigation**

I understand that my patient will be assessed by qualified clinic personnel who will provide education and decision support and initiate treatment as selected by patient.

My patient has an interest in:
___ Education/lifestyle change
___ Pelvic floor physical therapy
___ Pessary fitting

TREATMENTS ATTEMPTED:

☐ Lifestyle modification (weight loss, caffeine reduction)
☐ Home exercise program (Kegels)
☐ Pelvic floor physical therapy
☐ Pessary
☐ Medications _____
☐ Surgery

PERTINENT MEDICAL/SURGICAL HISTORY: Please attach all relevant documents

List of operations:

List of medications:

General comments:

INVESTIGATIONS: Please attach all relevant documents

NOTE: The Pelvic Floor Pathway Clinic assesses and treats patients with persistent, uncomplicated incontinence and prolapse. **If red flags are present, please refer directly to appropriate specialist.** Red flags indicating specialist assessment include hematuria, intractable UTIs, elevated post-residual volume, pelvic mass, possible fistula, possible neurologic lesion, cognitive impairment.

SURGICAL REFERRAL: If surgical care is selected, please direct my patient as follows:

☐ Back to me
☐ To a specific surgeon, Dr. _____
☐ Consultant Group, _____

CLINIC RESPONSE

Appointment date:

Patient completed assessment: ☐ yes ☐ no