AXIS | GYNECOLOGY

Referral Form

Patient Name:

Patient Email:

DOB (D-M-Y):

Health Card #:

Phone:

Referring Provider:

OHIP Billing #:

Office Phone:

Office Fax:

Reason for referral:

- ☐ Early pregnancy complications
- ☐ Abnormal bleeding
- ☐ Menstrual problems
- ☐ Contraception
- ☐ Vaginal discharge
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Vulvar skin conditions
- ☐ PAPs, IUDs and endometrial biopsies
- ☐ Other_____

How to ACCESS –

Fax referral including patient's email address. Patient will then be contacted by email to book appointment.

Patients may email axisgyne@gmail.com for more information.

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655 Bay St. 1007
Enter through 38 Elm St
Toronto, ON M5G2K4
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FAX: 416-283-8890
EMAIL axisgyne@gmail.com