



# Consultation Request Form Menopause Care

## PATIENT INFORMATION

Patient name \_\_\_\_\_  
Health card number \_\_\_\_\_ Version code \_\_\_\_\_  
Date of birth (DD/MM/YYYY) \_\_\_\_\_  
Email \_\_\_\_\_  
Address \_\_\_\_\_  
Patient phone number \_\_\_\_\_

## REFERRING PROVIDER

Referring provider \_\_\_\_\_  
Billing # \_\_\_\_\_  
Office phone number \_\_\_\_\_  
Office fax number \_\_\_\_\_

### Menopause Management Including Hormone Replacement Therapy (HRT)

#### REASON FOR REFERRAL

- |   |   |
|---|---|
| <input type="checkbox"/> Hot flashes      | <input type="checkbox"/> Musculoskeletal symptoms |
| <input type="checkbox"/> Night sweats     | <input type="checkbox"/> Brain fog                |
| <input type="checkbox"/> Weight gain      | <input type="checkbox"/> Other                    |
| <input type="checkbox"/> Mood changes     |   |
| <input type="checkbox"/> Decreased libido |   |

#### PLEASE SEND

- |  |
|--|
| <input type="checkbox"/> Recent blood work |
| <input type="checkbox"/> Last mammogram    |
| <input type="checkbox"/> Last Pap smear    |

**Please do not refer if: Past or present history of breast cancer, Undiagnosed vaginal bleeding, Bleeding disorder or history of DVT**

#### MEDICAL INFORMATION

---

---

---

---

---

#### MEDICATIONS

---

---

---

---

---

*Fully covered by OHIP, 100% in clinic visit*

*Due to the high volume of patients, care is provided for 12-18 months, after which follow-up is transitioned back to the Family Physician.*

**NO DE-ROSTERING: Referral will not trigger de-rostering or re-assignment as of April 1/2026**



**Dr. Lorena Barrientos**  
MD, FCFPC, Menopause Society Certified Practitioner  
Fax: 416-546-3657 Phone: 416-546-3487  
Email: admin@umedical.ca