

PESSARY REFERRAL FORM



Date: _____
Patient Name: _____
Address: _____
Phone: _____
Date of Birth: _____
Health Care Number: _____
Referring Physician: _____

****It is recommended that women who are post menopausal be supported with vaginal estrogen if being fit with a pessary to reduce the risk of vaginal erosion. Please assess and prescribe as you see fit****

In order for us to safely prescribe and fit this patient with a pessary, **please examine and clear the following medical contraindications:**

- Undiagnosed bleeding
- Severe vaginal atrophy
- Active vaginitis or urinary tract or other vulvar infection
- Ulceration of the cervix, the vagina, lacerations
- Uncontrolled diabetes
- Cancer of the vagina, uterus or bladder
- Active inflammatory disease of the pelvic floor
- Known silicone allergy
- Gynecological surgery (mesh)
- NO CONTRAINDICATIONS

Other notes or information: _____

Physician Signature: _____

If you have cleared all medical contraindications, please sign and fax to Elle Physiotherapy (403) 754-4391, or if you have concerns, please contact us to discuss how we should progress. Thank you for your care and collaboration with this patient.

Nicole Schmitt
Pelvic Health Physiotherapist