PESSARY REFERRAL FORM

Date:_____

Patient Name:_____

Address:_____

Phone:_____

Date of Birth:_____

Health Care Number:_____

Referring Physician:_____

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
- Gynaecological surgery (mesh)
- NO CONTRAINDICATIONS

Other notes or information: _____

_____

_____

_____

_____

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

Physician Signature:_____

If you have cleared all medical contraindications, can you 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