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Women's Health Referral Form

Client Name: ______________________________ Date: (yyyy/mm/dd) _________________

Birth Date: (yyyy/mm/dd) ____________________ Address: __________________________

Phone: __________________ Email: ____________________________

Date of Injury / Birth / Surgery (if any): _________

Referral Source: ___________________________ Address: __________________________

Phone: __________________ Fax: ______________________________

Diagnosis / Issue: ____

Contraindications/Precautions: ____

Service(s) Required:

- ☐ Pelvic Floor Therapy
  - ☐ Prenatal Preparation
    - ☐ Individual
    - ☐ Class (support person may also attend)
  - ☐ Postpartum: # weeks ________________
  - ☐ Diastasis Recti Abdominus
  - ☐ C-Section / Perineal Scar Management: ______________
  - ☐ Incontinence:
    - ☐ Urinary
    - ☐ Fecal
  - ☐ Urgency
  - ☐ Pelvic Organ Prolapse
    - ☐ Type: _______________________
  - ☐ Pain
    - ☐ Dyspareunia
    - ☐ Vaginismus
    - ☐ Vulvodynia
    - ☐ Vestibulodynia
    - ☐ Coccydynia
    - ☐ Other

- ☐ Chronic Condition:
  - ☐ Endometriosis
  - ☐ Adenomyosis
  - ☐ Interstitial Cystitis
  - ☐ Other:_______________________
- ☐ Sexual Function
  - ☐ Libido
  - ☐ Anorgasmia
  - ☐ Pain
  - ☐ Other: _______________________
- ☐ Abdominopelvic Surgery
  - ☐ Prehabilitation
    - ☐ Type:
    - ☐ Proposed Surgery Date: ____________
  - ☐ Post - rehabilitation
    - ☐ Type: __________________
    - ☐ Date:

- ☐ Mental Health Services
  - ☐ Maternal Mental Health
  - ☐ Anxiety
  - ☐ Depression
  - ☐ Other
- ☐ Stress Management
- ☐ Return to Fitness / Work
- ☐ Group Classes / Workshop
- ☐ Other: ____

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Report Requested Post-Assessment:

- ☐ Yes
- ☐ No

Treatment Updates requested:

- ☐ Every 3 visits
- ☐ Discharge
- ☐ Ongoing (chronic conditions)

Please print and fax to 587-760-1289 or email to info@e-motiontherapy.com