Pessary Referral Form

Patient's Name:________________________ Patient's Phone Number:________________

☐ Please contact patient directly

Referred for:

- ☐ Urinary Incontinence
- ☐ Pelvic Organ Prolapse
- ☐ Both

Previous Therapies:

- ☐ Pelvic Floor Physiotherapy
- ☐ Vaginal Estrogen
- ☐ OAB Medications

Has the patient been informed of the reason for this referral: ☐ Yes ☐ No

Type of request: ☐ Pelvic Floor Assessment ☐ Pessary fitting and follow up

Priority of referral: ☐ Routine ☐ Urgent

Investigations/Findings: ____

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Current and Past Management: ____

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Additional Comments:

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Referred by: ____________________________ Date: ____________________________

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