Kyle Winning, M.D., Med. Corp
Tahseen Mahdi, MBChB, C.C.F.P.
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217 5th Ave NE, P.O. Box 999, Altona MB R0G0B0, Tel: 204-324-6447, Fax: 204-324-5694

Referral Form
Vasectomy Service

First Name:	**Last Name:**
Address **PHIN:** **MHSC:**	**Home Phone:** **Mobile:** **Work:**
Date of Birth:	**Gender:** Male **Civil Status**: M S W D

Medical History:

Reason sterilization requested:

………

No. of children …………………………………………… Age of youngest child………………………………

Other obstetric history:

Current contraception used:

Other contraception considered and details of any intolerance:

Please detail any previous testicular history, other operations and relevant history:

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First Name:	**Last Name:**
Current medications:	
Known allergies:	
Any other comments:	
Is an interpreter required? No □ Yes □ What language?	
Referred by (please print) Signature Date of referral	