



AYA Referral Form

Please email and submit to aya@uhn.ca

Name:

Phone:

Pronouns:

Date of birth:

Email :

OHIP Number:

Address:

****Please mark any of the following reasons for referral**

- | | | |
|--|--|--|
| <input type="checkbox"/> URGENT Fertility | <input type="checkbox"/> Coping | <input type="checkbox"/> School |
| <input type="checkbox"/> Fertility | <input type="checkbox"/> Family Support | <input type="checkbox"/> Work |
| <input type="checkbox"/> Sexual Health | <input type="checkbox"/> Finances | <input type="checkbox"/> AYA Programming |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Transportation | |
| <input type="checkbox"/> Exercise/ Rehab | <input type="checkbox"/> Community Support | |
| <input type="checkbox"/> Symptom Management | | |
| <input type="checkbox"/> Body Image | | |
| <input type="checkbox"/> Sleep | | |
| <input type="checkbox"/> Other- please specify | | |

The AYA Program will reach out to you with your appointment time. Kindly email the AYA office if you do not receive information about your appointment within two weeks - aya@uhn.ca