

Pessary Referral Form

Thank you for referring your client to Core Connections Physiotherapy for a pessary fitting.

Please complete the form below to initiate the pessary fitting process and return the completed form by fax to (613) 907-1352.

If you have any questions, please contact us at (613) 291-2956.

Referring Physiotherapist

Name:
Clinic Name:
Clinic Phone #:
Email:
Client
Name:
Phone #:
Email:
Birth Date:
Client's Physician
Name:
Phone #:
Fax:

Description of client's key complaints and functional limitations		
Clinical Impression Please use this scale to describe the ty descent:	pe of prolapse and the extent of tissue	
the hymen	ose is more than 1 cm above the level of	
2 - The most distal portion of the prolap	ose is 1 cm above or below the hymenal	
3 - The most distal portion of the prolap	ose protrudes more than 1 cm below the	
hymen 4 - Vaginal eversion is essentially comp	plete	
Anterior wall	0 🗆 1 🗆 2 🗆 3 🗆 4 🗆	
Posterior wall prolapse	0	
Uterine prolapse	0	
Vault prolapse	0 🗆 1 🗆 2 🗆 3 🗆 4 🗆	
Response to pelvic floor physiothera	apy to date	
Dationals for a Danson (where also		
Rationale for a Pessary (please chec ☐ Decrease prolapse symptoms	ek ali that apply)	
☐ Delay or avoid pelvic prolapse surge	erv	
☐ Prevent progression of prolapse	9	
☐ Improve ability to exercise		
☐ Improve comfort		
☐ Improve bladder		
☐ Improve bowel emptying		
☐ Facilitate pelvic floor muscle strengt	hening	
☐ Other		

Is the client currently using local vaginal Estrogen? Yes □ Start date:
No 🗆
Please check any of the following factors below that could delay a pessary fitting ☐ Vaginal dryness ☐ Perineal or episiotomy scar tissue ☐ Significant pelvic floor muscle hypertonus and/or connective tissue restrictions
☐ Discomfort with vaginal palpation
☐ Decreased Dexterity
□ Other
Relevant medical history
Additional comments

Thank you very much for the referral.