HEMATOLOGY CLINIC REFERRAL

Form ID: Rev: June 21, 2019

Jim Pattison Outpatient Care and Surgery Centre
9750 140 Street, Surrey, BC, V3T 0G9
Tel: 604-582-4550 ext. 764191
Fax: 604-528-5441

Patient's Full Name: ____
First Middle Initial Last

Other Name(s): ______________________________ Gender: ☐ M ☐ F ☐ Non-binary

Personal Health Number: ______________________ Date of Birth: ____________________
DD/MM/YYY

Address: ____
Street City Province Postal Code

Phone: ______________________________________ ☐ Okay to Leave Message
Home Mobile

Alternate Contact: ____
Name Phone No.

Interpreter required? ☐ YES Language: ______________________________________

Insurance (if non-MSP): ________________ Isolation Precautions: ☐ Airborne ☐ Contact ☐ Droplet

Referral Priority: ☐ Non-urgent > 3 months ☐ Less-urgent < 4 weeks ☐ Urgent (contact Hematologist on call)

Medical Reason for Urgency: ____

REASON FOR REFERRAL & RELEVANT HISTORY

Referrals for benign hematology consultation only. Refer to BC Cancer Surrey for any malignant hematology diagnosis.

MEDICAL HISTORY: (*or attach medical record*)	**CURRENT MEDICATIONS:** *(or attach medication list)*

Referrals must include referral letter, most recent blood work including CBC, renal and liver function and any other relevant blood work, investigations (pathology, radiology, procedure reports), and consultations.

REFERRING HEALTH CARE PROVIDER	**FOR CLINIC USE ONLY**
Name: ____________________ MSP: ____________	Date: ______________ ☐ GHC
Phone: ______________ Fax: ______________	☐ TC ☐ Redirect to BCC-Surrey
Date: ______________ Title: ______________	☐ Additional Information Requested
Family Physician: (if different) ____________________	Urgency: ____________________