



fraserhealth

**BLADDER CARE REFERRAL  
JIM PATTISON OUTPATIENT CARE & SURGERY CENTRE**



MSXX104230C

Rev: Mar. 4/11

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**JPOCSC 9750 140th Street Surrey, B.C. V3T 0G9 FAX COMPLETED REFERRALS TO (604) 582-3787**

**Patient's Full Legal Name:** \_\_\_\_\_  
Last First Middle

**Other Name(s) (if applicable):** \_\_\_\_\_

**Personal Health Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Gender:** M  F   
(DD, MM, YYYY)

**Address:** \_\_\_\_\_  
Street City Province Postal Code

**Home Phone No.** \_\_\_\_\_  Okay to Call **Message Phone No.** \_\_\_\_\_

**Insurance Type**  MSP  WCB  Out-of-Province  Self-Pay Other: \_\_\_\_\_ RCMP or Armed Forces #: \_\_\_\_\_

**ALLERGIES**  NKA List Allergies: \_\_\_\_\_

**CURRENT MEDICATIONS:** (include OTC meds, vitamins, herbal remedies) \_\_\_\_\_

**Anticholinergic medications** \_\_\_\_\_

**MEDICAL HISTORY:**  (See attached urology consult letter)

**MOBILITY**  Independent  Requires assistance  Requires mechanical lift

**INTERPRETER**  No  Yes Language \_\_\_\_\_  Family member in attendance

<input type="checkbox"/> <b>Continence Clinic</b> Referral to Nurse Continence Advisor/Continence Physio Team	<input type="checkbox"/> <b>Urodynamic Clinic</b> Referral from Urologist, Gynecologist or Urogynecologist Only
<b>Reason for referral</b> <input type="checkbox"/> Urinary Incontinence/Overactive Bladder/Nocturia <input type="checkbox"/> Preoperative Continence Education Surgery: <input type="checkbox"/> Prostatectomy <b>Date:</b> _____ <input type="checkbox"/> Tension-free Vaginal Tape <b>Date:</b> _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Teaching Clean Intermittent Self-Catheterization (CISC) Reason for Catheterization: _____  <b>Priority Level:</b> Urgent <input type="checkbox"/> 2 - 4 wks <input type="checkbox"/> 4 - 6 wks <input type="checkbox"/>  <b>Preparation</b> <input type="checkbox"/> Voiding diary provided <input type="checkbox"/> Continence Clinic pamphlet provided <input type="checkbox"/> Urinalysis/Culture & Sensitivity ordered	<b>Reason for referral</b> <input type="checkbox"/> Urinary Incontinence/Overactive Bladder/Nocturia <input type="checkbox"/> Urinary Retention <input type="checkbox"/> Pre/Post operative <b>Date:</b> _____  <b>Risk Factor</b> <input type="checkbox"/> Spinal cord injury Specify level: _____ <input type="checkbox"/> Latex Allergy _____  <b>Preparation</b> <input type="checkbox"/> Anticholinergic medication stopped 5 days prior to test <input type="checkbox"/> Voiding diary provided <input type="checkbox"/> Urodynamic Test pamphlet provided <input type="checkbox"/> Urinalysis/Culture & Sensitivity ordered

**Family Physician (if different from referring source)**

Name: \_\_\_\_\_

MSP #: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient has no GP/NP

**Referring Health Care Provider:**

Name: \_\_\_\_\_

MSP #: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

GP  Specialist  NP  Hospitalist  ER

Printshop # 261991

**Referring Physician Signature:** \_\_\_\_\_