fraserhealth

BLADDER CARE REFERRAL
JIM PATTISON OUTPATIENT CARE & SURGERY CENTRE

MSXX104230C Rev: Mar. 4/11

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:** ___/___/___ (DD, MM, YYYY) **Gender: M** ☐ **F** ☐

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

☐ **Continence Clinic**
Referral to Nurse Continence Advisor/Continence Physio Team

Reason for referral
- ☐ Urinary Incontinence/Overactive Bladder/Nocturia
- ☐ Preoperative Continence Education
- Surgery: ☐ Prostatectomy **Date:** _____
- ☐ Tension-free Vaginal Tape **Date:** _____
- ☐ Other: _____
- ☐ Teaching Clean Intermittent Self-Catheterization (CISC)
  Reason for Catheterization: _____

Priority Level: **Urgent** ☐ **2 - 4 wks** ☐ **4 - 6 wks** ☐

Preparation
- ☐ Voiding diary provided
- ☐ Continence Clinic pamphlet provided
- ☐ Urinalysis/Culture & Sensitivity ordered

☐ **Urodynamic Clinic**
Referral from Urologist, Gynecologist or Urogynecologist Only

Reason for referral
- ☐ Urinary Incontinence/Overactive Bladder/Nocturia
- ☐ Urinary Retention
- ☐ Pre/Post operative Date: _____

Risk Factor
- ☐ Spinal cord injury
  Specify level: _____
- ☐ Latex Allergy _____

Preparation
- ☐ Anticholinergic medication stopped 5 days prior to test
- ☐ Voiding diary provided
- ☐ Urodynamic Test pamphlet provided
- ☐ 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 ☐

Referring Physician Signature: _____

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