fraserhealth

PROVINCIAL Health Services AUTHORITY

MATERNAL FETAL MEDICINE CLINIC REFERRAL

MSXX104476B REV: Sept. 10/12 Page: 1 of 1

☐ **Jim Pattison Outpatient Care and Surgery Centre**
9750 140th Street Surrey, B.C. V3T 0G9
Ph (604) 582-4558 EXT 763995

CENTRAL INTAKE
Fax All MFM Referrals to
(604) 582-3798

☐ **Royal Columbian Hospital**
330 Columbia St E
New Westminster B.C. V3L 3W7
Ph (604) 520-4132

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

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 #: _____

Interpreter Required: ☐ **No** ☐ **Yes** **Language:** _____

Age at referral:	**Age at EDC:**	
LMP: (DD/MM/YY) **Regular cycle?**	**Circle which is the final EDC** **EDC by LMP:** (DD/MM/YY) **EDC by U/S:** (DD/MM/YY)	**Date of earliest ultrasound:** (DD/MM/YY) **Gestational age at earliest ultrasound**
G T P SA TA L		**Multiple gestation:** ☐ **Yes** ☐ **No** ☐ **Twins** ☐ **Triplets** ☐ **Other**

Reason for Referral to Maternal Fetal Medicine: **(Please see reverse side for critieria details)**

- ☐ Pre-pregnancy planning
- ☐ Prenatal consultation (amniocentesis, NT)
- ☐ Maternal medical condition: _____
- ☐ Prior pregnancy concern: _____
- ☐ Present pregnancy concern: _____

Additional Comments:

Printshop # 261986

THE FOLLOWING RECORDS MUST BE RECEIVED TO PROCESS THIS REFERRAL

- ☐ Antenatal Record Part I and Part II (If started)
- ☐ Reports of all ultrasounds done in this pregnancy
- ☐ All available lab results; including serum integrated prenatal screen results, blood group and screen, CBC, prenatal screen, PAP smear results, FBS 2 hour OGTT (where indicated), A1C (within 3 months), electrolytes (if applicable, i.e. NVP), vaginal swabs
- ☐ All consultation reports and investigational records related to maternal diagnosis

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 ☐ Other

Referring Physician Signature: _____