



fraserhealth

OBSTETRIC INTERNAL MEDICINE REFERRAL

Jim Pattison Outpatient Care and Surgery Centre

Maternity Clinics - 3A



MSXX105751B

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Page: 1 of 1

Jim Pattison Outpatient Care and Surgery Centre
9750 140th Street Surrey, B.C. V3T 0G9
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Please check one of the following: Urgent 1 week
 2 weeks Routine (2-4 weeks)

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)

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:			Pre-registered at: SMH <input type="checkbox"/> LMH <input type="checkbox"/> PAH <input type="checkbox"/> Other <input type="checkbox"/>						
LMP: (DD/MM/YY)			Circle which is the final EDC			Date of earliest ultrasound: (DD/MM/YY)						
Regular cycle?			EDC by LMP: (DD/MM/YY)		EDC by U/S: (DD/MM/YY)		Gestational age at earliest ultrasound					
G	T	P	SA	TA	L	Multiple gestation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other						

Reason for Referral

- Pre-pregnancy planning Pregnant Post Partum
- Pre-eclampsia Chronic Kidney Disease Thrombocytopenia Palpitations
- Eclampsia Systemic Lupus Erythematosus Hypothyroidism Epilepsy
- Chronic HTN Other connective tissue disease Hyperthyroidism Viral hepatitis
- Gestational Hypertension Anemia Other endocrine abnormalities Other (must include comment)

Reason for Referral Comments: (must be completed)

THE FOLLOWING RECORDS MUST BE RECEIVED TO PROCESS THIS REFERRAL

- Antenatal Record Part I and Part II (If started)
- Reports of all Diagnostics that supports reason for referral
- 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/medical diagnoses

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

Office Use: 1 week 2 weeks 3 weeks 4 weeks

Referring Physician Signature: _____

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