fraserhealth

OBSTETRIC INTERNAL MEDICINE REFERRAL

Jim Pattison Outpatient Care and Surgery Centre
Maternity Clinics - 3A

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Jim Pattison Outpatient Care and Surgery Centre
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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** ☐ **LMH** ☐ **PAH** ☐ **Other** ☐
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

☐ **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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