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JPOCSC Maternity Clinics: POSTPARTUM CONTRACEPTION AND IUD CLINIC REFERRAL

Form ID: MSXX106766A New: July 17/16 Page: 1 of 1

JPOCSC Maternity Clinics 9750 140 Street, Surrey BC V3T 09G **Phone: (604) 582-4550 Ext 763992 Fax: (604) 582-3775**

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: ______/______/______
DAY MONTH YEAR

Address: ______________________________
Street City Province Postal Code

Home Phone No. ______________ **Cell Phone No:** ______________

Emergency Contact/Next of Kin: ______________ **Phone Number:** ______________

Insurance Type: ☐MSP ☐WCB ☐Out-of-Province ☐Self-Pay ☐Other:________ RCMP or Armed forces#:________

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

Reason for Referral:	**Delivery Information:**
☐ Postpartum contraception and intrauterine device counseling ☐ IUD insertion only: Insertions include PAP (if applicable) and STI screening	G ___ P ___ T ___ A ___ L ___ Date: ______________ Type of Birth: ______________

Patient Medical History:

☐ Active malignancy	☐ Active pelvic inflammatory Disease	☐ History of thromboembolic event
☐ Unexplained vaginal bleeding	☐ Known anatomic abnormalities	☐ Migraine headaches
☐ History of breast cancer	☐ Current breast disease	☐ Hypertension
☐ Seizure disorder on anticonvulsants	☐ Fibroids	☐ Other (please specify):________

Current Medications:	**Allergies:**
______________________________ ______________________________	______________________________ ______________________________

Please ensure the following are attached to this referral form:

☐ Antenatal records (if available) ☐ Most recent PAP report ☐ Labour and delivery records

Family Physician (if different from referring provider)	**Referring Health Care Provider:**
Name: ______________________ MSP #: ______________________ Phone: __________ Fax: __________ ☐ Patient has no GP/NP	Name: ______________________ MSP #: ______________________ Phone: __________ Fax: __________ ☐ GP ☐ Ob/Gyne ☐ NP ☐ MW ☐ Other

Referring Practitioner Signature: ______________ **Date of Referral:** ______________