fraserhealth

MATERNITY CLINICS DIETITIAN REFERRAL

JIM PATTISON OUTPATIENT CARE AND SURGERY CENTRE

MSXX104851A NEW: Aug. 2/11

JPOCSC 9750 140th Street Surrey, B.C. V3T 0G9 Phone: (604) 582-4558 ext 763993 Fax: (604) 582-3798

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** ☐
Height: _____ Pregravid weight: _____ Current weight: _____	**Circle which is the final EDC** **EDC by LMP:** (DD/MM/YY) **EDC by U/S:** (DD/MM/YY)	
G T P SA TA L		**Multiple gestation:** ☐ **Yes** ☐ **No** ☐ **Twins** ☐ **Triplets** ☐ **Other**

Reason for Referral:

- ☐ Inadequate nutrient intake
- ☐ Inadequate/ excessive weight gain
- ☐ Underweight/ overweight pre-pregnancy
- ☐ Nausea/ vomiting
- ☐ Food allergy or intolerance
- ☐ Poor eating habits
- ☐ Anemia
- ☐ IUGR
- ☐ Vegetarianism
- ☐ Other: _____

Additional Comments: *(e.g. if patient is not appropriate for group education phone patient directly etc.)*

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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: _____