NAUSEA AND VOMITING IN PREGNANCY CLINIC REFERRAL
JIM PATTISON OUTPATIENT CARE AND SURGERY CENTRE

MSXX104478A Rev: Nov 5/10

JPOCSC 9750 140th Street Surrey, B.C. V3T 0G9 Phone: (604) 582-4559 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** ☐
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**

Criteria for Referral to Nausea & Vomiting in Pregnancy Clinic: (Patient may self refer)

☐ History of excessive nausea and vomiting
Accompanied by: ☐ Signs and symptoms of dehydration
☐ Weight loss (7-8 lbs/3kg)

☐ No underlying health condition that contraindicated rapid IV infusion

☐ Patient has been started on Diclectin 4 tabs/day: ☐ **Yes** ☐ **No**

☐ Preprinted orders for NVP completed and signed

☐ Dating Ultrasound Done: ☐ **Yes** ☐ **No** If U/S not done is one booked: ☐ **Yes** ☐ **No**

Additional Comments:

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: ____________________

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