fraserhealth

SEAMLESS PERINATAL CARE REFERRAL

Form ID: NUXX105256D Rev: September 2018 Page: 1 of 1

Hospital Fax Numbers

ARH 604-851-4813	CGH 604-795-4155	LMH 604-533-6447	RCH 604-520-4183	SMH 604-588-3351
BGH 604-412-6237	JPOCSC 604-582-3798	PAH 604-535-4570	RMH 604-463-1886	

PATIENT INFORMATION - Please complete full			
Last Name	First Name(s):		Due Date (dd/mm/yyyy)
Date of Birth (dd/mm/yyyy)	Age		Care Card #
Address		Phone (h)	Phone (c)
Does patient self-identify as Aboriginal? ☐ Yes ☐ No	Does your patient want to speak with the Aboriginal Liaison Worker? ☐ Yes ☐ No		
Does your patient require an interpreter? ☐ Yes ☐ No If yes, language spoken:			
Is your patient a recent refugee or immigrant (less than 5 years in Canada)? ☐ Yes ☐ No If yes, country:			

REFERRAL INFORMATION - Please complete full		
Today's Date (dd/mm/yyyy)	Do you have your patient's consent for this referral? ☐ Yes ☐ No	
Planned Delivery Hospital ☐ ARHCC ☐ BGH ☐ CGH ☐ LMH ☐ PAH ☐ RCH ☐ RMH ☐ SMH		
Name of Referring Care Provider	☐ Dr ☐ Midwife ☐ SW ☐ PHN ☐ Other	
Address	Phone	Fax
Primary Care Provider (if different)	Phone	Fax

REASON FOR REFERRAL - Please check all that apply and include the BC Antenatal Record 1 & 2		
Medical Obstetric Factors		
☐ Antenatal RN referral requested		☐ Care plan requested
Social Factors		
☐ Single Parent	☐ Financial	☐ Housing
☐ Limited education	☐ Nutrition risk/food security	☐ Unplanned/denial of pregnancy
☐ Late prenatal care	☐ Isolated/lack of social support	☐ Limited transportation
Lifestyle Factors		
☐ Alcohol	☐ Substance use	☐ Tobacco Use
Maternal Mental Health		
☐ Current mental health illness/concerns (specify)		
☐ Developmental disability	☐ Previous traumatic birth	☐ Other
Relationship Safety		
☐ History of abuse	☐ Intimate partner violence	☐ Parenting capacity/difficulties
Comments		

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