fraserhealth

HEMATOLOGY CLINIC REFERRAL

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Centre 9750 140 Street, Surrey, 13C, V3T OG9
Tel: 604-582-4550 ext. 764191 Fax:
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Patient's Full Name: _____
First Middle Initial Last

Other Name(s): _____ Gender: ☐ M ☐ F ☐ Non-binary

Personal Health Number: _____ Date of Birth: _____
dd/mm/yyyy

Address: _____
Street City Province Postal Code

Phone: _____ ☐ Okay to Leave Message
Home Mobile

Alternate Contact: _____
Name Phone No.

Interpreter required? ☐ YES Language: _____

Insurance (if non-MSP): _____ Isolation Precautions: ☐ Airborne ☐ Contact ☐ Droplet

Referral Priority: ☐ Non-urgent > 3 months ☐ Less-urgent < 4 weeks ☐ Urgent (contact Hematologist on call)

Medical Reason for Urgency: _____

REASON FOR REFERRAL & RELEVANT HISTORY

Referrals for benign hematology consultation only. Refer to BC Cancer Surrey for any malignant hematology diagnosis.

MEDICAL HISTORY: *(or attach medical record)*	**CURRENT MEDICATIONS:** *(or attach medication list)*

Referrals must include referral letter, most recent blood work including CBC, renal and liver function and any other relevant blood work, investigations (pathology, radiology, procedure reports), and consultations.

REFERRING HEALTH CARE PROVIDER	**FOR CLINIC USE ONLY**
Name: _____ MSP: _____	Date: _____ ☐ GHC
Phone: _____ Fax: _____	☐ TC ☐ Redirect to BCC-Surrey
Date: _____ Title: _____	☐ Additional Information Requested
Family Physician: (if different) _____	Urgency: _____