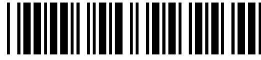
fraserhealth

PERINATAL COMPLEX CARE PLAN REFERRAL

Maternal, Infant, Child and Youth (MICY) Program



Form ID: MSXX107526B Rev: February 02, 2022

PLEASE COMPLETE IN FULL AND PRINT CLEARLY:

☐ **SMH FBU COMPLEX CARE PLAN TEAM**
Phone: (604) 649-1766 Fax: (604) 528-5448

☐ **RCH COMPLEX CARE PLAN TEAM**
Phone: (604) 520-4182 Fax: (604) 520-4183

PRIORITY

☐ **Emergent** (≤ 3 weeks from date of intended delivery) (May not be accommodated and will be on a case-by-case basis)

☐ **Urgent** (3-6 weeks from date of intended delivery)

☐ **Non-urgent** (≥ 6 weeks from date of intended delivery)

Patient's Full Legal Name ____________________
Last First Middle

Other Name(s) (if applicable) ____________________ **Personal Health Number** ____________________

Address ____________________
Street City Province Postal Code

Home Phone Number ____________________ **Alternate Phone Number** ____________________

Date of Birth ____________________ **Interpreter Required** ☐ **No** ☐ **Yes Language:** ____________________

Isolation Precautions: ☐ Routine ☐ Contact ☐ Droplet ☐ Airborne ☐ Other: ____________________

Age at Referral:	**Age at EDC:**	**G T P SA TA L**	
Physician Calculated EDC: (DD/MM/YYYY)	☐ **IVF/IC SI (if applicable)** Transfer Date (DD/MM/YYYY) 3-day or 5-day transfer (Circle one)	☐ **Early Ultrasound** (DD/MM/YYYY) **CRL** ________	☐ **Other: LMP/Late Ultrasound** **Details:**

Reason for Referral (examples on reverse) ****Note: Seamless Perinatal Care Referral Form (NUXX105256) also needed if social vulnerabilities present***

Delivery Plan:

☐ **Expectant management**

☐ **IOL booked for:** ____________________

☐ **C/S booked for:** ____________________

Consultants Involved:

THE FOLLOWING RECORDS MUST BE RECEIVED TO PROCESS THIS REFERRAL

☐ Antenatal Record Part 1 and 2

☐ Reports of all ultrasounds and diagnostic imaging

☐ All available lab results (including SIPS, CBC, OGTT etc.)

☐ All consultation reports and investigational records related to maternal/fetal diagnosis.

Referring Health Care Provider:
Name: ____________________
MSP #: ____________________
Phone: ____________ **Fax:** ____________

Most Responsible Provider:
Name: ____________________
MSP #: ____________________
Phone: ____________ **Fax:** ____________

PLEASE NOTE: AS THE MRP INITIATING THE COMPLEX CARE PLAN PROCESS, YOU ARE REQUIRED TO PROVIDE FEEDBACK WITHIN 7 DAYS OF RECEIVING A DRAFT CARE PLAN.

Referring Physician Signature: ____________________ **Date:** ____________________

COMPLEX CAREPLAN TEAM USE ONLY:

☐ **Approved**

☐ **Rejected** **Reason:** ____________________

Referral Received: ____________________

Priority Level: ____________________

Estimated Date of Initial Care Plan draft: ____________________

Indications for Complex Care Plan Referral

	Examples include but are not limited to:
Hematological Disorders	Von Willebrand's, ITP, Sickle-cell anemia, history of/or current thromboembolic event
Neurological Disorders	Epilepsy, previous CVA, Intracranial hypertension
Renal Disorders	Previous kidney transplant, chronic kidney failure
Endocrine Disorders	Hyperaldosteronism, Hyperparathyroidism, Grave's disease
Cardiac Disorders	Previous ASD/VSD repair, arrhythmias
Immunological Disorders	Systemic Lupus Erythematosus, Rheumatoid Arthritis
Respiratory Disorders	Asthma, Obstructive Sleep Apnea, cystic fibrosis
Gastrointestinal Disorders	Crohn's disease, Stoma, etc.
Infectious Diseases	Tuberculosis, HIV, Hepatitis C, COVID-19 etc.
Mental Health/Social	Substance-use disorder, acute mental health concerns (likely to impact inpatient stay) **Note: Please also complete a *Seamless Perinatal Care Referral Form (NUXX105256)* for these clients**
BMI	BMI greater than or equal to 50
Neonatal Considerations	Antibodies, Palliation, Fetal anomalies
Surgical Considerations	Placenta accrete, previous anesthetic complications, malignant hyperthermia risk, other surgical services need to be present
Special Circumstances	Mobility restrictions, Chronic pain, Surrogacy, Adoption, Jehovah's Witness etc.
Medications	Any medications outside standard obstetric care; increased obstetric complications (ex. Lithium, anticoagulants etc.)
Other	Any other condition that may warrant special planning for a patient's inpatient stay