Penicillin De-Labelling Clinic Referral
BC Women's Hospital
Phone: (604) 875-3073
Fax: (604) 875-3274

Appointment will be given directly to the patient

Date: ____________________

Name	Pronouns	Referral from: ☐ FP/Midwife/NP ☐ Other: ________________
DOB	PHN	
Address		**Referring Provider name**: ________________
City & Postal Code		Billing # :________________
Email	☐ OK for BCWH to contact patient via email	FAX: ________________
Phone Number Primary	Alternate	cc: ________________
Out of country/province ☐ No ☐ Yes Valid MSP ☐ No ☐ Yes Private pay ☐ No ☐ Yes	Identify as Indigenous ☐ No ☐ Yes Interpreter required ☐ No ☐ Yes Language spoken ________________	**Primary Care Provider outside of Pregnancy**: ________________

Please note that:

All criteria for referral must be met to be considered for acceptance in the Penicillin De-Labelling Clinic

- Pre-registered for deliver at BCWH or SPH
- Currently pregnant with a gestation < 36 weeks
- History of/or possible reaction to Penicillin/Amoxicillin

Pregnancy History

G _______ T _______ P _______ E _______ SA _______ TA _______ L _______

EDD: ___________ ☐ By Ultrasound

Isolation Needs

☐ MRSA +
☐ VRE +

Sent	Rec'd BCWH	Please attach the following documents:
☐	☐	Antenatal Record 1 & 2
☐	☐	Bloodwork/Labs
☐	☐	Consultations
☐	☐	Ultrasound or Diagnostic Reports

FOR BC WOMEN'S OFFICE USE ONLY

Appointment date: ______/______/______

Appointment time: ____________________

☐ Covid screening
☐ Scent free policy
☐ Consent email received
☐ Patient information sent

Referral reviewed by: ____________________

Date reviewed: ________________________

Incomplete Referrals will *not* be accepted