Neonatal Follow-Up Clinic – Referral Form

BC Women's Hospital and BC Children's Hospital
K3-184
4480 Oak Street
V6H 3V4
Telephone: (604) 875-2854
Fax: (604) 875-2483

Referring Hospital_____

Patient Information

Surname_____ First Name_____

Gender: □ Male □ Female DOB (day/mo/yr) _____/_____/_____

PHN_____ Hospital Unit Number_____

Birth weight _____ Gestation_____ EDC (day/mo/yr) _____/_____/_____

Referral Criteria: Please check all that apply ☑

□ Birth weight ≤ 800g
□Gestational Age < 26 weeks
□Congenital Diaphragmatic Hernia
□ROP >Grade III or Laser Surgery
□MiCare recruit (<29 weeks gestation born in Canada)
□Grade IV IVH
□Cystic PVL
□ECMO
□Patients discharged home on oxygen

Comments: _____

Parent and Legal Guardian Information

Parent Names (Mo) _____ (Fa) _____
Address_____
Phone_____ Cell_____

Physician Information

Referring Physician_____Phone_____

Family Physician_____Phone_____

Please Fax to (604) 875-2483 along with Discharge Summary.
Thank you for your Referral.