Maternal Pelvic Health Clinic
BC Women's Hospital
Phone (604) 875-3706
Fax (604) 875-2491

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

Appointment will be given directly to the patient Date: _____

Name	Pronouns	**Referral from:** ☐ GP/ Midwife/ NP Office ☐ OB/GYN Office ☐ Urology ☐ BCWH Internal: _____ ☐ Other _____
DOB	PHN	
Address		
City & Postal Code		**Referring provider name**: _____ Billing # : _____
Email	Consent to Email ☐ No ☐ Yes	
Phone Number Primary	Alternate	Phone: _____
Identify as Indigenous ☐No ☐ Yes Valid MSP ☐No ☐ Yes Private pay ☐No ☐ Yes	Interpreter required ☐No ☐ Yes Interpreter booked ☐No ☐ Yes Language spoken _____	cc: _____ cc: _____

Please note that:

- We only accept referrals for patients pre-registered or previously delivered at BC Women's Hospital
- We are unable to accommodate patients with Pelvic Organ Prolapse, Urinary Incontinence, Overactive Bladder, and Rectovaginal Fistula from Inflammatory Bowel Disease

Reason for Referral

☐ Antepartum prior OASIS
☐ Postpartum prior OASIS, no AS*
☐ Postpartum prior OASIS, with AS
☐ Fistula (low rectovaginal from obstetrical trauma)
☐ Other: _____
_____

Pregnancy History

G_____T_____ P_____ SA_____ TA_____ L_____

EDD: *Day* _____ *Month*_____ *Year* _____
Date of last delivery: *Day*_____ *Month*_____ *Year*_____

Type of prior perineal tear:
☐ 3a degree tear
☐ 3b degree tear
☐ 3c degree tear
☐ 4th degree tear

Method of last delivery:
☐ SVD
☐ forceps-assisted
☐ vacuum-assisted
☐ Other:
_____

Notes:
_____
_____
_____
_____

Please send copies of the following:

☐ Laboratory results
☐ Results of pelvic exam, if done
☐ Consultation(s)

** AS is defined as anal symptoms of fecal urgency or leak of stool, flatus, or both*