

**Complex Contraception Clinic**

BC Women's Hospital  
 Phone (604) 875-3137  
 Fax (778) 504-9805



**Appointment will be given directly to the patient**

Date: \_\_\_\_\_

Name		<b>Referral from:</b> <input type="checkbox"/> BCW Urgent Care Centre <input type="checkbox"/> GP/NP Office <input type="checkbox"/> OB/Gyne Office <input type="checkbox"/> ED <input type="checkbox"/> Fertility Centre <input type="checkbox"/> Other _____
Preferred Name	Pronouns	
DOB	PHN	
Address, City & Postal Code		
Email	Consent to Email	<b>Referring provider name:</b> _____ Billing # : _____ cc: _____ cc: _____
Primary <input type="checkbox"/> No <input type="checkbox"/> Yes Alternate <input type="checkbox"/> No <input type="checkbox"/> Yes	Interpretor required <input type="checkbox"/> No <input type="checkbox"/> Yes Interpreter booked <input type="checkbox"/> No <input type="checkbox"/> Yes Language spoken _____	
Identify as Indigenous	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Valid MSP	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Private pay	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**Please note that:**

- Our clinic does not offer sedation services for contraceptive procedures. If your patient requires sedation services or a higher level of care, please refer to local Gynecologist
- Same day contraception insertion is only offered to patients that bring their implant to the initial visit
- For patients requiring Pessary care, please refer to Urogynecology
- Accepted patients will receive an initial consultation with a gynecologist. Follow-up will be booked as required

**Reason for Referral**

Complex medical condition(s) that are ≥ 1 relative or absolute contraindication to contraceptive use  
 Please list contraindication: \_\_\_\_\_

Complex medical condition(s) requesting menstrual suppression

Previous difficult Implant/IUD insertion

Difficult Contraceptive Implant/IUD removal

Current malpositioned Implant/IUD

Provider to Provider consult only

**Relevant History:**

\_\_\_\_\_

\_\_\_\_\_

**Special Considerations:**

▪ Positive for ARO's?  No  Yes

▪ Does the patient have a disability?  No  Yes Nature of Disability: \_\_\_\_\_

▪ Does the patient have transfer requirements?  No  Self  Board  Requires lift

If yes, will an attendant accompany the patient?  No  Yes *(this is advised if require help transferring)*

Done	Not Done	Send copies of the following if available:
<input type="checkbox"/>	<input type="checkbox"/>	Consultation(s)
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasounds
<input type="checkbox"/>	<input type="checkbox"/>	Laboratory results