Allergy Challenge Clinic Referral
BC Women's Hospital
Phone: (604) 875-3073
Fax: (778) 504-9803

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

Appointment will be given directly to the patient

Date: _____

Name	Pronouns
DOB	PHN
Address	
City & Postal Code	
Email	☐ OK for BCWH to contact patient via email
Phone Number Primary	Alternate

Referral from:
☐ FP/Midwife/NP
☐ Gynecologist
☐ Other: _____

Referring Provider name:
_____
Billing # :_____
FAX: _____
cc: _____
PCP outside of Pregnancy:
_____

Out of country/province	☐ No	☐ Yes	Identify as Indigenous	☐ No	☐ Yes
Valid MSP	☐ No	☐ Yes	Interpreter required	☐ No	☐ Yes
Private pay	☐ No	☐ Yes	Language spoken	_____	

Please note that:

All criteria for referral must be met to be considered for acceptance in the Allergy Challenge 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: _____

☐ Book routine (28-36wks)
☐ Book urgent: _____

Incomplete Referrals will *not* be accepted