

ACCESS Clinic
 BC Women's Hospital
 Phone (604) 875-3290
 Fax (778) 504-9804



Appointment will be given directly to the patient

Date: _____

Name _____		Pronouns _____		Referral from:	
DOB _____		PHN _____		<input type="checkbox"/> GP/ Midwife/ NP Office <input type="checkbox"/> OB/GYN Office <input type="checkbox"/> Urology <input type="checkbox"/> Self Referral <input type="checkbox"/> Other _____	
Address _____					
City & Postal Code _____					
Email _____		Consent to Email		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Phone Number _____					
Primary			Alternate		
Identify as Indigenous		<input type="checkbox"/> No <input type="checkbox"/> Yes		Interpreter required	
Valid MSP		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Private pay		<input type="checkbox"/> No <input type="checkbox"/> Yes		Language spoken _____	
Referring provider name: _____					
Billing # : _____					
Phone: _____					
cc: _____					
cc: _____					

Please note that:

- Access Clinic provides gynecological health care for persons who cannot access these services in their primary health care providers office or clinic. This typically includes **persons with physical or intellectual disabilities, previous traumatic pelvic exams, a history of sexual abuse, or obesity** who require an accessible exam table
- HPV screening is an alternative to the Pap test for regular cervix screening. HPV self-screening swabs are now available through the BCCA website, for those that may feel more comfortable with self collection

Reason for Referral

<input type="checkbox"/> Pelvic Exam/Pap	<input type="checkbox"/> Menstrual Suppression
<input type="checkbox"/> Sexual Health Counselling	<input type="checkbox"/> Post Menopausal Bleeding/Endometrial Biopsy
<input type="checkbox"/> Reproductive Health Counselling, <i>including contraception</i>	<input type="checkbox"/> Vaginal Dilator Therapy
<input type="checkbox"/> Other: _____	

Relevant History *(include cervical cytology and other relevant consults and test results)*

Other Booking Information

Nature of Disability: _____

Transfer Requirements	Will an attendant be accompanying:
<input type="checkbox"/> Self	<input type="checkbox"/> Yes
<input type="checkbox"/> One person assist	<input type="checkbox"/> No
<input type="checkbox"/> Board	
<input type="checkbox"/> Lift required	

Transportation: _____