Obstetric Anesthesia Clinic Referral Request Form

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

Phone: 604-875-2989 Fax: 604-602-8649

Date of referral: _____/_____/_____
DD/MTH/YEAR

OK For BCW Hospital to contact patient via email?
☐ **YES** ☐ **NO**
EMAIL:_____

Referral For

PATIENT NAME OR LABEL

PHN: _____

Phone: _____

G___ T___ P___ A___ L____

EDD: _____ □1st trimester U/

Intended Mode of Delivery (if known)

❒ Vaginal Birth

❒ Induction Date/GA: _____

❒ Cesarean Birth Date/GA: _____

Consults Initiated

Maternal

❒ Maternal Fetal Medicine
❒ Obstetrician
❒ Internal Medicine
❒ Diabetes
❒ Hematology
❒ Perinatal Addictions
❒ Advanced Collaborative Care Plan (ACCP
❒ Other: _____

Please send additional documentation :

❒ Antenatal Records 1 and 2
❒ Consultation Reports (Maternal)
❒ Consultation Reports (Fetal)
❒ Labs
❒ Diagnostic Imaging:
  ❒ Obstetrical Ultrasound
  ❒ Maternal Echo

Other:_____

Referral Timelines

❒ See at 32-34 weeks gestation age (routine)

❒ See urgently / ASAP

❒ Postpartum (specify reason)
_____

Requesting MRP

MRP: _____

Office Phone: _____

Fax: _____

Indication(s) for Referral

❑ Obstetric conditions
❑ Patient / provider request
❑ Anticipated anesthesia-related problems
❑ Cardiovascular disorders
❑ Respiratory disorders
❑ Hematological disorders
❑ Neurological disorders
❑ Renal disorders
❑ Endocrine disorders
❑ Autoimmune disorders
❑ Connective tissue disorders
❑ Other:
_____
_____
_____

Interpreter Service:

❒ Required Language:
_____
❒ Not Required

Referral Details:

Developed by

BCW Anesthesia Department – Medical Lead

Version History

DATE	DOCUMENT NUMBER and TITLE	ACTION TAKEN
09-Sept-2021	C-06-06-62594 Obstetric Anesthesia Clinic Referral Request Form	Approved at: BCW Ambulatory Leadership Committee
23-Jul-2024	“	Maternal Newborn Committee

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