

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: ____/____/____ <small style="text-align: center;">DD/MTH/YEAR</small>	OK For BCW Hospital to contact patient via email? <input type="checkbox"/> YES <input type="checkbox"/> NO EMAIL: _____		
Referral For	Referral Timelines		
PATIENT NAME OR LABEL PHN: _____ Phone: _____	<input type="checkbox"/> See at 32-34 weeks gestation age (routine) <input type="checkbox"/> See urgently / ASAP <input type="checkbox"/> Postpartum (specify reason) _____		
G__ T__ P__ A__ L__ EDD: _____ <input type="checkbox"/> 1 st trimester U/	<p style="text-align: center;">Requesting MRP</p> MRP: _____ Office Phone: _____ Fax: _____		
Intended Mode of Delivery (if known)			
<input type="checkbox"/> Vaginal Birth			
<input type="checkbox"/> Induction Date/GA: _____			
<input type="checkbox"/> Cesarean Birth Date/GA: _____			
Consults Initiated			
Maternal <input type="checkbox"/> Maternal Fetal Medicine <input type="checkbox"/> Obstetrician <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Hematology <input type="checkbox"/> Perinatal Addictions <input type="checkbox"/> Advanced Collaborative Care Plan (ACCP) <input type="checkbox"/> Other: _____			
Please send additional documentation :			
<input type="checkbox"/> Antenatal Records 1 and 2 <input type="checkbox"/> Consultation Reports (Maternal) <input type="checkbox"/> Consultation Reports (Fetal) <input type="checkbox"/> Labs <input type="checkbox"/> Diagnostic Imaging: <input type="checkbox"/> Obstetrical Ultrasound <input type="checkbox"/> Maternal Echo Other: _____			
Indication(s) for Referral			
<table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none; vertical-align: top;"> <input type="checkbox"/> Obstetric conditions <input type="checkbox"/> Patient / provider request <input type="checkbox"/> Anticipated anesthesia-related problems <input type="checkbox"/> Cardiovascular disorders <input type="checkbox"/> Respiratory disorders <input type="checkbox"/> Hematological disorders </td> <td style="width:50%; border: none; vertical-align: top;"> <input type="checkbox"/> Neurological disorders <input type="checkbox"/> Renal disorders <input type="checkbox"/> Endocrine disorders <input type="checkbox"/> Autoimmune disorders <input type="checkbox"/> Connective tissue disorders <input type="checkbox"/> Other: _____ _____ _____ </td> </tr> </table>		<input type="checkbox"/> Obstetric conditions <input type="checkbox"/> Patient / provider request <input type="checkbox"/> Anticipated anesthesia-related problems <input type="checkbox"/> Cardiovascular disorders <input type="checkbox"/> Respiratory disorders <input type="checkbox"/> Hematological disorders	<input type="checkbox"/> Neurological disorders <input type="checkbox"/> Renal disorders <input type="checkbox"/> Endocrine disorders <input type="checkbox"/> Autoimmune disorders <input type="checkbox"/> Connective tissue disorders <input type="checkbox"/> Other: _____ _____ _____
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Interpreter Service:			
<input type="checkbox"/> Required Language: _____ <input type="checkbox"/> 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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