Referral
Continence Clinic

BC Women's Hospital
Phone: (604) 875-3137
Fax: (604) 875-3136

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Appointment will be given directly to the patient

Woman's Name *(first and last)*	**Referral** ☐ Self Referral ☐ Care Giver
Phone Number Home Work Cell	
Address	Referring Caregiver name: _____
City/ Town & Postal Code	Phone:_____
Date of Birth *(day/month/year)*	Fax: _____
MSP/ PHN	Billing # _____ cc other Caregiver – name: _____
Out of country/province ☐ No ☐ Yes Language Spoken_____	Language barrier ☐ No ☐ Yes Interpreter required ☐ No ☐ Yes

Pregnancy History
G_____ T_____ P_____ SA_____ TA _____E _____ L_____

Reason For Referral ☐ Urinary Incontinence ☐ Fecal Incontinence ☐ Pelvic Organ Prolapse ☐ Post Partum ☐ Pregnant ☐ Interstitial Cystitis	☐ **Other referrals:** _____ _____ _____ _____

Send copies if the following area available:
☐ Laboratory results
☐ Results of pelvic exam if done
☐ Consultation(s)