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

Centre for Pelvic Pain & Endometriosis Clinic Referral

BC Women's Hospital + Health Centre
F2-4500 Oak St., Vancouver, BC V6H 3N1
T 604.875.2534 / F 604.875.2569
www.bcwomens.ca

Date: _____(DD / MM / YYYY)

A: PATIENT INFORMATION ❑ New Patient ❑ Re-Referral

Patient Name: _____ PHN: _____
Email: _____ Phone number: _____
Address: _____ City/Town: _____
Date of Birth: _____ (DD/MM/YYYY) Pronouns: _____
Fluent English ❑Y ❑ N Interpreter Required ❑Y ❑N Language _____ Identify as Indigenous ❑Y ❑N

B: REFERRING CARE PROVIDER

Name: _____ MSP# _____
Phone: _____ Fax: _____
❑GP ❑Specialist ❑Other: _____

C: PRIMARY CARE PROVIDER (if different from referring)

Name: _____ MSP# _____
Phone :_____ Fax: _____

D: ADVICE CALL *Note: this is for patients not being referred to the clinic*

❑ **Advice call for community gynecologists** (call will be scheduled within one week). Details:

E: CLINIC REFERRAL **REQUIRED: Complete all fields**

1. Who agrees to continue care?	❑Referring provider, or ❑Primary provider
2. Does the patient have any **exclusion criteria**? Lives outside BC/YT or No MSP Age <16 or > 55 Currently pregnant/postpartum < 6 mos Unstable/Untreated psychiatric issues Untreated/ongoing substance use Post-menopausal (surgical or natural) Vestibulitis/vulvodynia/introital dyspareunia only Myofascial/back pain only Neuropathic pain only Urogyne (mesh, tape complications, prolapse)	❑ No
3. **SELECT (1) ONE REASON FOR REFERRAL**: **(A)** Confirmed **surgical** or **imaging/clinical diagnosis** of advanced endometriosis: ovarian endometrioma >3cm deep endometriosis (bowel, ureter, bladder) extra-pelvic endometriosis **OR** **(B) Persistent pelvic pain** unresponsive to first line management AND has been **assessed and treated by a gynecologist** in the last 3 years?	❑ **If reason (A)** ❑ Supporting surgical, pathology, and/or imaging reports, and consult reports attached (mandatory) Patient wants surgery? (select one) ❑ Yes ❑ No ❑ Undecided ❑ **If reason (B)** ❑ Gyne consult letter attached (mandatory) Treatments tried (select all that apply): ❑IUD ❑Surgery ❑Progestin ❑CHC/combined contraception ❑GnRH agonist/antagonist
4. Is this an **URGENT referral?**	❑ No ❑ Yes, details:
5. Other relevant information	(optional) ❑ see attached

Fax completed referral and required documents to: 604-875-2569

Referrals will not be accepted until all information is received and all fields are complete. Patients accepted into the clinic will be contacted directly by our office.

The clinic has a standardized approach and is program-based. Your patient will be scheduled with the next available physician to minimize waiting time.

We do not assume opioid prescribing. There are no addiction services in our clinic.