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

Referral Form
COMPLEX CONTRACEPTION CLINIC (CCC)
BC Women's Hospital and Health Centre
Phone: (604) 875-3290
Fax: (604) 875-3009

PLEASE FAX FORM TO 604-875-3009	**WE WILL CONTACT PATIENT WITH AN APPOINTMENT**
Patient Information **Last Name:**	**First Name:**
Address:	PHN:
Email:	Phone:
Referring Provider:	MSP#:
Primary Care Provider:	

REASON FOR REFERRAL

Reason for Referral. Please indicate at least one of the following:

- ❑ ≥ 1 Absolute or Relative Contraindication to hormonal and/or non-hormonal contraception
    - Please list contraindication: ____
- ❑ Current malpositioned IUD
- ❑ Previous difficult IUD insertion

Relevant history:

Please send copies of all pertinent investigations: ***Incomplete referral forms will not be accepted***

- ❑ **Laboratory results**
- ❑ **Ultrasounds**
- ❑ **Consultation(s)**

Please note that all patients will be triaged and receive an initial consultation with a gynecologist. Follow-up will be booked as required. **OUR CLINIC DOES NOT OFFER SAME-DAY IUD INSERTION UNLESS PATIENT BRINGS IUD TO INITIAL VISIT**.

SPECIAL CONSIDERATIONS

1. Is this patient MRSA Positive? □ Yes □ No
2. Does the patient have a disability? □ Yes □ No Nature of Disability:
3. Does the patient have Transfer Requirements: □ No □ Self □ Board □ Requires lift
    a. If yes, will an attendant be coming with the patient (this is advised if require help transferring)? □ Yes □ No

FOR OFFICE USE ONY

- ❑ Left a Message with Patient
- ❑ Booked/Date:

This form is for the sole use of the intended recipient(s) and contains confidential and privileged information. Any unauthorized use, disclosure or distribution is prohibited. If you are not the intended recipient please contact the sender and destroy all copies.