

Complex Contraception Clinic

BC Women's Hospital
 Phone (604) 875-3290
 Fax (778) 504-9805



Appointment will be given directly to the patient

Date: _____

Name		Referral from: <input type="checkbox"/> BCW Urgent Care Centre <input type="checkbox"/> GP/NP Office <input type="checkbox"/> OB/Gyne Office <input type="checkbox"/> ED <input type="checkbox"/> Fertility Centre <input type="checkbox"/> Other _____
Preferred Name	Pronouns	
DOB	PHN	
Address, City & Postal Code		
Email	Consent to Email	Referring provider name: _____ Billing # : _____ cc: _____ cc: _____
Primary <input type="checkbox"/> No <input type="checkbox"/> Yes	Alternate <input type="checkbox"/> No <input type="checkbox"/> Yes	
Identify as Indigenous <input type="checkbox"/> No <input type="checkbox"/> Yes	Interpreter required <input type="checkbox"/> No <input type="checkbox"/> Yes	
Valid MSP <input type="checkbox"/> No <input type="checkbox"/> Yes	Interpreter booked <input type="checkbox"/> No <input type="checkbox"/> Yes	
Private pay <input type="checkbox"/> No <input type="checkbox"/> Yes	Language spoken _____	

Please note that:

- Our clinic does not offer sedation services for contraceptive procedures. If your patient requires sedation services or a higher level of care, please refer to local Gynecologist
- Same day contraception insertion is only offered to patients that bring their implant to the initial visit
- For patients requiring Pessary care, please refer to Urogynecology
- Accepted patients will receive an initial consultation with a gynecologist. Follow-up will be booked as required

Reason for Referral

Complex medical condition(s) that are ≥ 1 relative or absolute contraindication to contraceptive use
 Please list contraindication: _____

Complex medical condition(s) requesting menstrual suppression

Previous difficult Implant/IUD insertion

Difficult Contraceptive Implant/IUD removal

Current malpositioned Implant/IUD

Provider to Provider consult only

Relevant History:

Special Considerations:

▪ Positive for ARO's? No Yes

▪ Does the patient have a disability? No Yes Nature of Disability: _____

▪ Does the patient have transfer requirements? No Self Board Requires lift

If yes, will an attendant accompany the patient? No Yes *(this is advised if require help transferring)*

Done	Not Done	Send copies of the following if available:
<input type="checkbox"/>	<input type="checkbox"/>	Consultation(s)
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasounds
<input type="checkbox"/>	<input type="checkbox"/>	Laboratory results