# FIR Referral Form

BC Women's Hospital + Health Centre
4500 Oak Street, Vancouver, BC
V6H 3N1
Tel: 604 875 2229 Fax: 604 875 2221
www.bcwomens.ca/fir

| **Estimated Delivery Date** | |
|---|---|
| **Expected date/time of arrival:** | |

**Instructions:** Please complete the referral form and return by fax to 604 875 2221.
***Incomplete forms will be accepted and reviewed***

| **Date:** | **Time:** |
|---|---|
| ☐ **Antepartum Care** ☐ **Postpartum care** | |

| **Patient Information (patient will be contacted by FIR team to assess eligibility)** | | |
|---|---|---|
| **Patient Name:** | **Personal Health Number:** | **Date of Birth:** |
| **Address:** | | |
| **Phone:** | **Email:** | |
| **Identify as Indigenous:** ☐ **Yes** ☐ **No** | **Status No.:** | |
| **Referral submitted with patient's consent:** ☐ **Yes** ☐ **No** | **Reason/details if no consent:** | |

| **Referral Source** | |
|---|---|
| **Name:** | **Service/Position:** |
| **Self-Referral:** ☐ **Yes** ☐ **No** | **Phone:** |

| **Key Community Supports (FIR team may contact supports listed below):** | |
|---|---|
| **Does the patient have supports for the following:** | |
| **Housing:** ☐ **Yes** ☐ **No** | **If yes, list contact information:** |
| **Income Support:** ☐ **Yes** ☐ **No** | **If yes, list contact information:** |
| **Community SW:** ☐ **Yes** ☐ **No** | **If yes, list contact information:** |

| Key Community Supports (continued) | |
|---|---|
| Counselling: ☐ Yes ☐ No | If yes, list contact information: |
| Public Health: ☐ Yes ☐ No | If yes, list contact information: |
| Other supports (list contact information): | |

| Key Personal Supports (i.e., Partner, Family, Friends) | |
|---|---|
| Name of support #1: | |
| Email: | Phone: |
| Address: | Relationship: |
| Name of support #2: | |
| Email: | Phone: |
| Address: | Relationship: |

| Early exit plan for all patients (not stabilized but can no longer stay on FIR due to ongoing use, violence, etc.): | | |
|---|---|---|
| Support contact: | | |
| Name: | Phone: | Address: |
| Name: | Phone: | Address: |
| Name: | Phone: | Address: |
| Preferred Pharmacy: | Fax: | Address: |

| Patient Substance Use History:<br>(this information is used to best support patient's medical needs) | | |
|---|---|---|
| **Substance of choice:** | **Estimated amount/day:** | **Preferred method of use:** |
| **Previous treatments received for substance use:** ☐ **Yes** ☐ **No**<br>**If yes, provide details:** | | |
| **Longest time in recovery:** | | |

| Mental Health History (previous and/or current): | |
|---|---|
| **Mental health concerns (indicate if previous or current and if diagnosis was received):** | |
| **Previous or current medications taken for mental health:** ☐ **Yes** ☐ **No**<br>**If yes, please list medications, indicating if previous or current, and effectiveness:** | |
| **Previous substance use psychosis:** ☐ **Yes** ☐ **No** | **If yes, indicate duration:** |

| Other areas of vulnerability and structural barriers (add comments if applicable): |
|---|
| **Intimate partner violence:** |
| **Overdose:** |
| **Self-harm:** |
| **Others:** |

| Areas of strength and self-efficacy (add comments): |
|---|
| |

| Obstetrical history: | | |
|---|---|---|
| **First pregnancy:** ☐ Yes ☐ No | **No. of children given birth to:** | **No. of children living with patient:** |
| **Date of most recent ultrasound:** | **Currently receiving prenatal care:** ☐ Yes ☐ No<br>**If yes, list providers:** | |
| **Previous FIR patient:** ☐ Yes ☐ No | **If yes, did patient feel supported:** ☐ Yes ☐ No<br>**Comments:** | |

## Non-obstetrical medial concerns:

**List other current medical concerns:**

**Current medications:**

## Other comments:

## Action box:

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority
MENTAL HEALTH AND SUBSTANCE USE PROGRAMS + INITIATIVES