

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

Due 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:
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Patient Information		
Patient Name:	PHN:	DOB:
Address:		
Telephone:	Email:	
Identify as Indigenous: <input type="checkbox"/> Yes <input type="checkbox"/> No Status No.: _____	Referral submitted with patient's consent: <input type="checkbox"/> Yes <input type="checkbox"/> No	FIR Team can contact patient directly: <input type="checkbox"/> Yes <input type="checkbox"/> No

Referral Source	
Name:	Service/Position:
Self-Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone:

Key Support:		
Can FIR Team contact key supports? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name:	Email:	Telephone:
Address:		
Is woman connected to Community Health Care team: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Care Team:	_____	
Contact Name:	_____	
Phone Number:	_____	

Goal of Admission (Check all that apply):		
Stabilization of Substance Use <input type="checkbox"/>	Intra partum care <input type="checkbox"/>	Postpartum care <input type="checkbox"/>
Undetermined – ie. No/limited prenatal care <input type="checkbox"/>		
Current safety concerns: IPV <input type="checkbox"/> Overdose Risk <input type="checkbox"/> Self Harm <input type="checkbox"/> Homeless <input type="checkbox"/>		
Patient Personal History:		
Substance(s) used		
Opioids <input type="checkbox"/> Stimulants <input type="checkbox"/> Alcohol <input type="checkbox"/> Non-beverage alcohol <input type="checkbox"/> Benzodiazepines <input type="checkbox"/>		
Other: _____		
Experienced an overdose in the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional comments if yes? _____		
List all medications:		

Medical/mental health concerns		

Obstetrical History:		
G ___ P ___ A ___ L ___	Gestational age:	Most recent ultrasound date:
Obstetric risks:		
What prenatal care was provided and from whom:		

Housing Status
Current housing status:
Plan post discharge:

Action Box

FOR INTERNAL USE ONLY: REFERRAL INFORMATION

DATE REFERRAL RECEIVED:

PROJECTED ADISSION DATE:

DATE REFERRAL REVIEWED BY FIR TRIAGETEAM:

FIR PHYSICIAN INVOLVED:

DATE ADMISSION WAS OFFERED:

DATE ADMISSION ACCEPTED:

DATE ADMISSION REFUSED:

DATE ADMISSION POSTPONED AND REASON

DATE OF CONTACT ATTEMPTS & BY WHO