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

Complex Chronic Disease Program (CCDP)
Tel: (604) 875-2061 Fax: (604) 875-3738
B432- 4500 Oak Street, Vancouver, BC, V6H 3N1

REFERRAL FORM

Date of Referral : _____

Please include relevant reports with this referral:

Consults ☐

Imaging ☐

Lab work ☐

Other (eg: sleep studies, EMG) ☐

Eligibility Criteria for Referrals:

- Symptoms or diagnosis of Fibromyalgia and/or ME/CFS
- Or chronic symptoms of Tick borne Illness (eg. Lyme disease)
- Referred by the patient's primary care professional (GP, NP or ND)
- Patient's GP, NP, or ND is available to provide ongoing care
- BC resident, aged 19 & over

Patient Information :

_____ _____ _____ _____
(PATIENT SURNAME, FIRST) (PREVIOUS / MAIDEN NAME) (DOB: YY/MM/DD) (PHN)

_____ _____ _____ _____
(STREET ADDRESS) (HOME PHONE) (WORK PHONE) (CELL PHONE)

_____ _____ _____
(CITY) (POSTAL CODE) (EMAIL)

Does this patient need an interpreter? ☐ YES: _____ (language)

Reason for Referral:

New patient referral ☐ **Re-referral** ☐

Please note: You must be the patient's primary care provider to refer to the CCDP. We do not accept referrals for patients with suspected acute Lyme disease. If a consult with an Infectious Disease specialist is required, please follow your usual referral pathway.

Primary Care Provider Information:

NAME: **SIGNATURE:** _____

ADDRESS: **BILLING NO:**

PHONE NUMBER:

FAX NUMBER: **EMAIL:**