

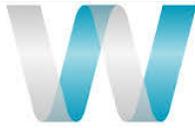
SURNAME		FIRST NAME	
PERMANENT ADDRESS			
POSTAL CODE	CELL	HOME PHONE	WORK PHONE
DATE OF BIRTH (D/M/Y) PHN		AGE	

Date of Referral (D/M/Y):		Is patient aware of referral?	<input type="checkbox"/> No <input type="checkbox"/> Yes						
Is it OK for BC Women's Hospital to contact patient?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Interpreter Required? (see reverse)	<input type="checkbox"/> No <input type="checkbox"/> Yes, language:						
Referring Provider:		MSP Billing #:							
Phone:		FAX:							
Primary Care Provider (if not the same as above):		MSP Billing #:							
Reason for Referral:									
Urgency:	<input type="checkbox"/> Routine	<input type="checkbox"/> ASAP	<input type="checkbox"/> Urgent						
Requesting:	<input type="checkbox"/> In person consult	<input type="checkbox"/> Virtual/phone	<input type="checkbox"/> Provider to provider						
Transportation Issues:	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Details:							
Pregnant Patients:									
G	T	P	ECT	SA	TA	L	LNMP (d/m/y)	EDD (d/m/y)	GA (as of date of referral)
							/ /	/ /	

PLEASE CHOOSE THE CORRECT SECTION BELOW AND PROVIDE ALL DOCUMENTATION REQUESTED:

All Referrals	Adult HIV Care	Reproductive infectious Disease/ HIV preconception/ HIV Antenatal Care:	Congenital infection Clinic/ Pediatric & Youth HIV Care
<input type="checkbox"/> Consultation Letter <input type="checkbox"/> Recent labs & diagnostics (including PAP)	<input type="checkbox"/> Recent viral load & CD4 <u>nPEP & PrEP:</u> <input type="checkbox"/> Recent negative HIV screen <input type="checkbox"/> Cr/GFR <input type="checkbox"/> AST/ALT	<input type="checkbox"/> Current antenatal records (if pregnant) <input type="checkbox"/> Antenatal records from previous pregnancy <input type="checkbox"/> Dating ultrasound (if pregnant) <input type="checkbox"/> For recurrent infectious vaginitis: recent vaginal swab/ culture results with proven bacterial vaginosis or vaginal candidiasis <u>HCV Treatment:</u> <input type="checkbox"/> HCV PCR & Viral Load <input type="checkbox"/> Genotype (preferred but not essential) <input type="checkbox"/> AST/ALT/Bilirubin	If available: <input type="checkbox"/> Antenatal records <input type="checkbox"/> Birth record <input type="checkbox"/> Maternal serology

Once all documentation is received, we will triage your referral and contact the patient directly with an appointment.
Thank you for your referral.



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Provincial Language Service Interpretation Criteria:

- Patient will be asked to sign an **informed consent** for treatment/procedure *and* the patient is not fully fluent in English.
- Patient has little or no English language skills *and* has no responsible adult friend/family member to translate for them during the clinical encounter. Note: Children are not suitable translators for patients.

The Provincial Language Service comes with significant cost.

If your patient has basic English language skills and can manage their own appointment that does not include consent, diagnosis, or treatment, do not request an interpreter.

All information and medical terminology should be explained in simple English so the use of an interpreter is not necessary for most appointment types.

Should we determine there is in fact a need, we will access interpretation support via telephone which is an effective modality for interpreting health care as indicated in the most recent literature and current best practices.

Thank you for your cooperation and support.

Oak Tree Clinic,

BC Women's Hospital & Health Centre