**SUBJECT: Oak Tree Clinic Referral – MRN**

# Oak Tree Clinic: Congenital Infectious Diseases – BCCW Internal Referral Form

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| --- | --- | --- | --- | --- |
| **Referral Date** |  | | | |
| **Information for Referring Provider** | | | | |
| **Provider Name** |  | **Contact Number** | |  |
| **Clinic or Program** |  | **Fax Number** | |  |
| **Please, attach with referral:**   * Relevant maternal/birthing individual investigations * Infant/child relevant investigations * Antenatal Imaging | | | | |
| **Other Involved Healthcare Professionals** | | | | |
| **Name/ Discipline/ Contact** |  | **Name/ Discipline/ Contact** | |  |
| **Name/ Discipline/ Contact** |  | **Name/ Discipline/ Contact** | |  |
|  | | | | |
| **Patient Name** (LAST, First) |  | **Date of Birth**  (dd-mmm-yy) | |  |
| **Preferred Name** (if applicable) |  | **Country of Birth** | |  |
| **MRN** |  | **Address** | |  |
| **PHN** |  |
| **Sex** | Male Female Other |
|  | | | | |
| **Parent Name(s)/**  **Legal Gaurdian(s) if different from above** | Parent Name: | | Legal Gaurdian Name: | |
| Home/Cell Phone: | | Home/Cell Phone: | |
| Email: | | Email: | |
| Maternal PHN: | |  | |
|  | | | | |
| **Caregiver & Legal guardians if not in care of parents** | Name: | | Name: | |
| Home/Cell Phone: | | Home/Cell Phone: | |
| Email: | | Email: | |
|  | | | | |
| **Interpreter Required** | Yes  No | **If yes, language:** | |  |
| **Isolation Required** | Yes  No | **If yes, type:** | | Airborne  Contact  Droplet/Contact  Details: |
| **Reason for Referral/Other Notes (ex. Alerts, MCFD):** | | | | |

**PLEASE SEND COMPLETED REFERRALS TO:**

* Email: [oaktree@cw.bc.ca](mailto:oaktree@cw.bc.ca)
* Fax: 604-875-3063

|  |  |  |  |
| --- | --- | --- | --- |
| **FOR INTERNAL USE ONLY:**  To be seen:  Date specified  1-3 weeks  4-6 weeks  Within 3 months Within 6 months | | | |
| Date Received | Click here to enter a date. | Accepted/Declined | Click here to enter a date. |
| Date Entered | Click here to enter a date. | Date of Visit | Click here to enter a date. |
| Date Triaged | Click here to enter a date. | Time of Visit | Click here to enter text. |

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