Maternal Pelvic Health Clinic
BC Women's Hospital
Phone (604) 875-3732
Fax (604) 875-2491

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

Appointment will be given directly to the patient Date:

Name Pronouns	**Referral from:** ☐ GP/ Midwife/ NP Office ☐ OB/GYN Office ☐ Urology ☐ BCWH Internal: _____ ☐ Other _____
DOB PHN	
Address	
City & Postal Code	**Referring provider name**: _____ Billing #: _____
Email Consent to Email ☐ No ☐ Yes	Phone: _____
Phone Number Primary Alternate	cc: _____ cc: _____
Identify as Indigenous ☐ No ☐ Yes Interpreter required ☐ No ☐ Yes	
Valid MSP ☐ No ☐ Yes Interpreter booked ☐ No ☐ Yes	
Private pay ☐ No ☐ Yes Language spoken _____	

Please note that:

- We only accept referrals for patients pre-registered or previously delivered at BC Women's Hospital
- We are unable to accommodate patients with Pelvic Organ Prolapse, Urinary Incontinence, Overactive Bladder, and Rectovaginal Fistula from Inflammatory Bowel Disease

Reason for Referral

☐ Antepartum prior OASIS
☐ Postpartum prior OASIS, no AS*
☐ Postpartum prior OASIS, with AS
☐ Fistula (low rectovaginal from obstetrical trauma)
☐ Other: _____

Pregnancy History

G____T____P____SA___TA___L____

EDD: *Day*____ *Month* _____ *Year* _____

Date of last delivery: *Day*___ *Month*____*Year* ____

Type of prior perineal tear:
☐ 3a degree tear
☐ 3b degree tear
☐ 3c degree tear
☐ 4th degree tear

Method of last delivery:
☐ SVD
☐ forceps-assisted
☐ vacuum-assisted
☐ Other: _____

Notes:

Please send copies of the following if <u>not</u> available on CST Cerner or CareConnect:

☐ Results of pelvic exam, if done
☐ Consultation(s)

** AS is defined as anal symptoms of fecal urgency or leak of stool, flatus, or both*