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

MENOPAUSE + MIDLIFE HEALTH PROGRAMS

Bone Marrow Transplant Clinic
B4-4500 Oak St.
Vancouver, BC V6H-3N1
T: 604.875.2322 F: 604.675.2652

REFERRAL FORM - Bone Marrow Transplant Clinic

Date of Referral: _____

New Patient ☐ Re-referral ☐

Patient Name:_____ PHN (Personal Health Number):_____

Address: _____ Primary Phone Number: _____

Date of Birth (DD/MM/YYYY):_____

Email:_____ ☐ Consent to contact by email

Referring Provider: _____MSP#_____ ☐ Specialist ☐ GP ☐ Other_____

Primary Care Provider (if different from referring) _____

Who agrees to continue care? ☐ Referring Provider ☐Primary Care Provider

Does the patient identify as Indigenous (First Nations, Metis, Inuit)? ☐ Yes ☐ No

Is an Interpreter required? ☐ Yes ☐ No Language Required:_____

Does the patient prefer to attend the appointment: ☐ Virtual ☐ In Person ☐ Either

Diagnosis

☐ Routine ☐ Urgent: Post-Menopausal Bleeding or Adnexal Mass >5CM

Chronic GVHD N/H Grade: ☐ Mild ☐ Moderate ☐ Severe

Sites Involved – Score:	Skin	Mouth	Eyes	GI Tract	GT	Liver	Lungs	Joints/Fascia

Reason for Referral:

Secondary Diagnosis

1.
2.
3.
4.

Conditioning Regimen: ☐ Fully Ablative ☐ Reduced Intensity ☐ TBI

History of Chronic Steroid Use: ☐ Yes ☐ No

Current Medications:		
1.	4.	7.
2.	5.	8.
3.	6.	9.

Date of Transplant:	
Type of Transplant:	☐ PBSCT ☐ BMT ☐ Related ☐ Unrelated
Other Comments:	

Violence screening

Does this patient have a history of aggression?	Yes ☐	No ☐
If yes:	Verbal ☐	Physical ☐

Please provide a brief description of the history of verbal and/or physical aggression incidents, outcomes and date of last occurrence (e.g. throwing objects, hitting someone, yelling).

_____

Effective Intervention(s)

_____