**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
* Fax: 604-875-3063

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| --- |
| **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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