

PHYSICIAN REFERRAL FORM

IF YOU ARE A PHYSICIAN AND WANT TO REFER YOUR PATIENT TO THE FPMS PLEASE COMPLETE THE FOLLOWING FORM:

THIS FORM MAY BE PRINTED AND FAXED (FAX: 604.875.3950)

REFERRING PHYSICIAN: NAME _____ MSP
BILLING NUMBER _____ PHONE _____

FAX _____

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____
DATE OF BIRTH (YYMMDD): _____
BC PERSONAL HEALTH NUMBER _____
ADDRESS: _____
CITY: _____ PROVINCE: _____ POSTAL CODE: _____
DAYTIME PHONE: _____ CELL PHONE: _____
EDD (YYMMDD): _____
OBSTETRICAL HISTORY: _____

MEDICAL HISTORY: _____

SOCIAL HISTORY: _____

PLEASE FAX IF AVAILABLE:

ANTENATAL RECORD PART 1 ANTENATAL RECORD PART 2 ALL PRENATAL BLOODWORK AND LABORATORY TESTS, INCLUDING: RECENT PAP AND CULTURES MATERNAL SERUM SCREEN, ULTRASOUND REPORT(S) PERTINENT CONSULTATIONS

I WOULD LIKE TO REQUEST A SPECIFIC DOCTOR: _____

We will contact you by phone or return fax in a few days with an appointment for your patient within 2 weeks of receiving the referral.

- **For an urgent appointment** call: 604.875.3436
- **For an emergency assessment** call: 604.875.2161 ask for Family Practice Maternity Service doctor-on-call.
- **For the Perinatal Addictions Service** in an emergency call: 875.2161 ask for Family Practice Maternity Service Group 2 doctor.

Any questions call
604.875.3436