Providence HEALTH CARE

PRIMARY CARE MATERNITY CLINIC
REFERRAL

Primary Care Maternity Clinic - St. Paul's Hospital
Room 541, 5th floor, Burrard Building
1081 Burrard Street, Vancouver

Phone: 604-806-9342
FAX: 604-639-8506
Email: maternityclinic@providencehealth.bc.ca

Date of referral: _____

FAX all relevant information including current medications, allergies, and diagnostic reports with the completed referral, including Antenatal Record if started.

Appointment requested for: ☐ Self-referral (complete as much information below as possible)

First name: _____ Last name: _____

Address: _____ DOB: (DD/MMM/YY) _____

_____ PHN #: _____

Telephone number(s): _____

Patient email: _____

First day of last menstrual period: _____

Date of last cervical cancer screening: _____

Previous testing: If the following labs and ultrasound have already been done, please indicate and fax results with the completed referral:

- ☐ *CBC*
- ☐ *ABO blood group and antibodies*
- ☐ *Serologies: HIV, varicella, rubella titre, HCV, HBSAg, syphilis*
- ☐ *TSH*
- ☐ *Urine C&S*
- ☐ *Urine for chlamydia and gonorrhea*
- ☐ *First dating ultrasound between EGA 7-11 weeks*

Referring source: ***Name*** ***Phone number***

☐ Family Physician: _____

☐ Obstetrician: _____

☐ Midwife: _____

Signature: _____ Billing No: _____

Fax completed referral to 604-639-8506