Division of Pediatric
Hematology/Oncology/Blood & Marrow Transplant

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Hematology Patient Referral Form
This form must be completed before an appointment will be made

Dear Physician colleague,

Thank you very much for your referral. Please help us to serve your patient better by filling out ALL the following information clearly, **and attach ALL relevant laboratory reports and fax to us at 604-875-2911**. All new hematology referrals are reviewed by the hematologist-on-service at the time of referral. A Hematologist may call you to clarify any information sent. **For urgent referrals call 604-875-2161 and ask to speak to the Hematologist on call.**

Date of Referral: ________________________

Patient Name: ________________________

DOB: ____________________ ☐ **M** ☐ **F**

Mailing Address: ________________________

____

Phone: ________________________(**H**)

________________________**(W)**

MRUN: ________________________

PHN#: ________________________

Ref MD: ________________________

Ref MD Phone: ________________________

Primary MD: ________________________

Parents/Guardians: ________________________

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Reason for Referral *(Please clearly state your clinical question or concern):*

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Relevant Past Medical History:

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Has the patient been seen previously by a Hematologist at BC Children's Hospital?

☐ **Y** ☐ **N** **If yes, Name**: ________________________

URGENCY OF REFERRAL:

☐ **Today – Phone 604-875-2161 and ask to speak to the Hematologist on call**

☐ **Within 2 weeks – Phone 604-875-2161 and ask to speak to the Hematologist on call**

☐ **Within 1 month – Fax referral, all relevant lab reports and medical information to 604-875-2911**

☐ **Within 6 months – Fax referral, all relevant lab reports and medical information to 604-875-2911**

Clear Form