



BCCH COMPLEX CARE PROGRAM
<http://www.bcchildrens.ca/our-services/clinics/complex-care>
 Phone: 236-989-7997 Fax: 604-642-8828 BCCHComplexCare@cw.bc.ca

Referral Date: _____

REFERRAL FORM

Name		Referring Provider (MD or NP)	
Date of Birth		Family Physician or Primary Care Nurse Practitioner	
BCCH MRN			
PHN		Community Pediatrician	
Phone		Our program relies on a <i>consultative</i> relationship with the community ped. Therefore, <i>all</i> referrals need to be discussed by the referring provider with the community pediatrician	Date of discussion: _____
Town/City			
Legal Guardian(s)			
		Main social worker involved and their contact	

Primary Diagnosis:
Additional concerns:

Describe how you would like Complex Care to be involved with this child:

** Referrals will NOT be accepted for the sole purpose of coordinating appointments*

Criteria for Referral (Must meet criteria #1-5):

1. Actively followed by 3 or more sub-specialists. * "Actively" means outpatient visits at least twice a year.

- 2. History of frequent visits and/or hospitalizations at BCCH
- 3. High intensity care and/or dependence on technology
- 4. Age less than 16 years
- 5. **NOT** already primarily followed by a multidisciplinary clinic at BCCH (ex: Neuromuscular, Spina Bifida, Oncology)

For patient referrals that do not fulfill all criteria, please contact us for further discussion.

Please attach any relevant reports to the referral.

We would also like to know if psychosocial complexity exists.

- Psychosocial complexity:** Circumstances that making caring for a child with medical complexity more challenging and/or barriers to social determinants of health (e.g., living in poverty, new to Canada or BC, parental mental health concerns, low literacy or non-English speaking, racism). Please provide details in another document.