G.F. STRONG REHAB CENTRE
A part of the Vancouver Coastal Health Authority

SEXUAL HEALTH REHABILITATION SERVICE REFERRAL FORM

Date of Referral (MM/DD/YY):	
Client Name:	**Medical Record Number:** **Account Number:**
Address:	
Telephone:	**If GFS Client:** ☐ **IP** ☐ **OP** **Estimated Discharge Date:**
Birthdate: (MM/DD/YY):	**Program:**
Diagnosis:	**Date of Onset (MM/DDYY):**
Reason for Referral:	
Relevant History:	
Physician:	
Referring Clinician:	**Clinician Telephone:** **E-mail Address:**

Please submit this referral form to the Sexual Health Rehab Service either via:
a) internal mail (at VCH) or
b) fax to SHRS at 604-714-4191 or
c) regular mail to: Sexual Health Rehab Service, GF Strong Rehab Centre,
4255 Laurel Street, Vancouver, BC V5Z 2G9

Questions please call 604-737-6233 **Thank you**