Clinic
Referring Physician
Phone
Fax
MSP

SAMPLE – Transfer Referral Cover Sheet

Dear: Date:

Re: (Patient Name)
Date of Birth:
PHN:
Phone:
Address:
Patient requires interpreter: Yes _____ Language _____
Intellectual delay or non-verbal – please contact:
Name: _____ Phone: _____

This letter is to request **Consultation** and **Transfer of Medical Care** from BC Children's Hospital to Adult Services of the above named patient.

His/her Diagnosis(es) include: (list all)

Other Medical Practitioners include:
Family Practitioner
Name:
Phone: Fax:

Pediatric Specialist	Adult Specialist

Please confirm that you will accept this patient into your practice and see the patient within ___ weeks/ months of transfer. (Fax back confirmation to: _____).

Physician Name: _____ Phone: _____

Date of Patient Visit: _____
Cc: Hospital Record