BCCH Pediatric & Adolescent Gynecology Referral

4480 Oak Street, Vancouver, BC V6H 3V4
Ambulatory Care Building, Area 5
BCCH Fax: 604-642-8891 **Phone:** 604-875-2345 ext. 5749

Fraser Health Referral Fax: 604-953-0338

INCOMPLETE REFERRALS WILL BE RETURNED

Referral Date: (dd/mm/yyyy)	

Patient Information

Last Name	**First Name**	**Date of Birth** (dd/mm/yyyy)
Preferred Name:		**Pronouns:** ☐ She/her ☐ He/him ☐ They/Them ☐ Other
BC PHN		**Gender** (as indicated on the patient's Care Card) ☐ M ☐ F ☐ X
Parent/Guardian Name(s)		**Language** ☐ English ☐ Other (specify): / **Interpreter Required?** ☐ No ☐ Yes
Address Building Number Street Name Suite/Apt Number City/Town Province Postal Code		**Phone:** / **Email:**

Referral Source *MANDATORY* (complete section below *or* attach office letterhead)

Last Name	**First Name**	**MSP**	**Phone**	**Fax**

Primary Care Provider

Last Name	**First Name**	**MSP**	**Phone**	**Fax**

To be seen by:

☐ First Available	☐ Dr. D. Millar ☐ Dr. N. Todd ☐ Dr. A. Sachedina	☐ Dr. T. Justice (Fraser Health)

Reason for Referral (Check all that apply)**:**	☐ Adolescent Obstetrics ☐ Amenorrhea, primary ☐ Amenorrhea, secondary ☐ Contraception ☐ Dysmenorrhea ☐ Heavy menstrual bleeding ☐ Irregular menstrual bleeding ☐ Pubertal disorder – delayed, precocious ☐ Uterine/Cervical/Vaginal abnormality ☐ Vulvovaginitis ☐ Other (please indicate):

Investigations Completed (please include copies of all testing):	**Test**	**Date of Testing**
	☐ Ultrasound	Mm/dd/yyyy
	☐ CT	Mm/dd/yyyy

BCCH Pediatric & Adolescent Gynecology Referral

4480 Oak Street, Vancouver, BC V6H 3V4
Ambulatory Care Building, Area 5
BCCH Fax: 604-642-8891 **Phone:** 604-875-2345 ext. 5749

Fraser Health Referral Fax: 604-953-0338

	☐ MRI	Mm/dd/yyyy
	☐ Bloodwork (e.g., FSH + estradiol)	Mm/dd/yyyy
	☐ Culture	Mm/dd/yyyy
	☐ Growth curve	Mm/dd/yyyy
	☐ Consultation	Mm/dd/yyyy
Additional Information		