SURREY MEMORIAL HOSPITAL
PEDIATRIC CARDIOLOGY CLINIC

British Columbia's Children's Hospital
an agency of the Provincial Health Services Authority

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Better health. Best in health care.

REFERRAL FORM

All sections must be completed in order to book appointment. If not completely filled out, requisition will be returned to referring office.

Patient Surname_____ **First Name** _____

DOB (DD/MM/YYYY) _____ **PHN** _____ **Male** _____ **Female** _____

Mother's Name _____ **Father's Name** _____

Daytime Phone Number _____ **Alternate Phone Number** _____

Address: _____

Interpreter Required? Y___ **N**_____ **Language**_____

Please Provide Clinical Detail:

_____

_____

_____

_____

Previous Assessments by Cardiologists _____ **Year:** _____

Family Physician_____

Referring Physician _____ **Billing #** _____ **Phone #**_____

Signature_____ **Date**_____

Please fax to (604) 875-3541 or mail B.C Children's Hospital, Cardiology Partnership Program. Room 1C-54, 4480 Oak Street, Vancouver, B.C. V6H 3V4.

For BCCH Office Use Only:

Reason for Referral: ☐ Initial Diagnosis/Assessment ☐ Follow Up To Be Seen ☐ Urgent ☐ Within 4 weeks ☐ Elective

Tentative Appt Date _____ Tests Required: ☐ Echo ☐ ECG Appointment Length: _____

Comments: _____

_____

Follow up: ☐ No ☐ Yes Date: _____ Intake Date: _____ Signature: _____