



Division of Pediatric
Hematology / Oncology / Bone Marrow Transplant

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Hematology Patient Referral Form

This form must be completed before an appointment will be made

Dear Physician colleague,

Thank you very much for your referral. Please help us to serve your patient better by filling out ALL the following information clearly, **and attach ALL relevant laboratory reports and fax to us at the number on the bottom of the page.** A Hematologist may call you to clarify any information sent. All new hematology referrals are reviewed by the hematologist-on-service at the time of referral. **For urgent referrals call 604 875-2161 and ask to speak to the Hematologist on call.**

DATE OF REFERRAL: _____

Patient Name: _____

DOB: _____ M F

Mailing Address: _____

Phone: _____ (H) _____ (W)

PHN#: _____

REF MD: _____

Address: _____

Phone: _____

Family MD: _____

Parents: _____

Reason for Referral (*Please clearly state your clinical question or concern*):

Relevant Past Medical History:

Has the patient been seen previously by a Hematologist at BC Children's Hospital?

Y N If yes, Name: _____

URGENCY OF REFERRAL:

Today – Phone 604 875-2161 and ask to speak to the Hematologist on call.

Within 2 weeks – Phone 604 875-2161 and ask to speak to the Hematologist on call.

Within 1 month – Attach all relevant lab reports and medical information.

Within 6 months – Attach all relevant lab reports and medical information.