BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

COMPLEX CARE PROGRAM

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REFERRAL FORM

Referral Date:_____

Name		**Referring Provider (MD or NP)**	
Date of Birth		**Family Physician**	
BCCH MRN		**Pediatrician**	
PHN		**Main health care professional involved**	
Phone		**We recommend to discuss with main health care professional involved prior to referral. Was this done?**	☐ Yes ☐ No
Town/City			
Legal Guardian			

Primary Diagnosis:
Additional concerns:

Describe how you would like Complex Care to be involved with this child:

** Referrals will NOT be accepted for the sole purpose of coordinating appointments*

Criteria for Referral (Must meet criteria #1-5):

1. Actively followed by 3 or more sub-specialists. Please list:
   ** "Actively" means outpatient visits at least twice a year*.

2. History of frequent visits and/or hospitalizations at BCCH
3. High intensity care and/or dependence on technology
4. Age less than 16 years
5. **NOT** already primarily followed by a multidisciplinary clinic at BCCH (ex: Neuromuscular, Spina Bifida, Oncology)

For patient referrals that do not fulfill all criteria, please contact us for further discussion. Our webpage has more information**.** *http://www.bcchildrens.ca/our-services/clinics/complex-care*

We would also like to know if

☐**Psychosocial**: Concern about this family's ability to cope/manage the care of their child with complexity given their circumstances (e.g. living in poverty, new to Canada or BC, parental mental health concerns). Please provide details if possible.