BCCH COMPLEX CARE PROGRAM

http://www.bcchildrens.ca/our-services/clinics/complex-care

K1-111, Clinic 7, Ambulatory Care Building, BCCH
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Referral Date:_____

REFERRAL FORM

Name		**Referring Provider (MD or NP)**	
Date of Birth		**Family Physician or Primary Care Nurse Practitioner**	
BCCH MRN			
PHN		**Community Pediatrician**	
Phone		**Our program relies on a *consultative* relationship with the community ped. Therefore, *all* referrals need to be discussed by the referring provider with the community pediatrician**	Date of discussion: _____
Town/City			
Legal Guardian(s)			
		Main social worker involved and their contact	

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. ** "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.

☐ Please attach any relevant reports to the referral

We would also like to know if psychosocial complexity exists

☐ **Psychosocial complexity**: Circumstances that making caring for a child with medical complexity more challenging and/or barriers to social determinants of health (e.g. living in poverty, new to Canada or BC, parental mental health concerns, low literacy or non-English speaking, racism). Please provide details in another document.