SPINAL CORD CLINIC
BC Children's Hospital
4500 Oak Street, Vancouver, BC. V6H 3N1

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PHYSICIAN REFERRAL FORM

Date of Referral: _____

CHILD'S FULL NAME: (First, Last): _____

Birthdate: (day/ month/ year): _____ Gender: _____

PHN: _____ □ Ambulatory □ Non-ambulatory Child is a recent refugee? □ Yes □ No
Do they have an Interim Federal Health Certificate of Eligibility? □ Yes (Please send a copy) □ No

Address: _____
Postal Code: _____
City: _____

Home phone: (_____) _____ Work phone: (_____)_____

Email: _____

Child lives with: Mother: _____ Father: _____ Foster Family: _____

Legal Guardian Name(s): _____ Phone: (_____) _____

Legal Guardian Address: _____

City: _____ Postal Code:_____

Interpreter required: ☐ Yes ☐ No Language: _____

Child's Current and/or Working Diagnosis:

Reason For Referral:

PLEASE ATTACH A COPY OF ALL PERTINENT □ CONSULTS □ REPORTS AND □ MEDICAL INVESTIGATIONS
(ie: CT Scan, EEG, MRI, Ultrasounds, Labs – Chromosomes, Psychology Testing, Developmental Testing etc)

REFERRING PHYSICIAN: (Print Name) _____ Billing Number: _____

PHYSICIAN SIGNATURE: _____

Address: _____ (city)_____ (postal code)_____

Office telephone (_____) _____ Fax number: (_____)_____

Name of Family Physician: _____

Pediatrician: _____