BCCH Vascular Anomalies Referral

4480 Oak Street, Vancouver, BC V6H 3N1
Ambulatory Care Building, A242
Fax: 604-642-8893 **Phone:** 604-875-2291

INCOMPLETE REFERRALS WILL BE RETURNED

Referral Date	(dd/mm/yyyy)

Patient Information

Last Name (free text)	**First Name** (free text)	**Date of Birth** (dd/mm/yyyy)
Preferred Name:	**Pronouns:** ☐ She/her ☐ He/him ☐ They/Them ☐ Other	
BC PHN (###-###-###)	**Gender** (as indicated on the patient's Care Card) ☐ M ☐ F ☐ X	
Parent/Guardian Name(s)	**Language** ☐ English ☐ Other (specify): (free text)	**Interpreter Required?** ☐ No ☐ Yes
Address (free text) Suite/Apt Number; (free text) Building Number; (free text) Street Name; (free text) City/Town; (free text) Province; (free text) Postal Code		**Phone** (###-###-####) **Email** (free text)

Referral Source *MANDATORY* (complete section below *or* attach office letterhead)

Last Name (free text)	**First Name** (free text)	**MSP** (########)	**Phone** (###-###-####)	**Fax** (###-###-####)

Primary Care Provider (if different from referring provider)

Last Name (free text)	**First Name** (free text)	**MSP** (########)	**Phone** (###-###-####)	**Fax** (###-###-####)

Reason for Referral – Please attach History & Examination

Investigations Completed	**Test**	**Date of Testing**
****Please include copies of all testing****	☐ Ultrasound	dd/mm/yyyy
	☐ CT	dd/mm/yyyy
	☐ MRI	dd/mm/yyyy
	☐ Lab results (including pathology)	dd/mm/yyyy
	☐ Photographs	dd/mm/yyyy
	☐ Previous Treatment (Radiology, surgery, medications, etc.)	dd/mm/yyyy
	☐ Previous Therapies (OT, PT, RMT, etc.)	[free text]
	☐ Consultations	[free text]

Additional Information