CROSSROADS OBSTETRICS & GYNAECOLOGY

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REFERRAL FORM – OBSTETRICS

Your office will be informed of appointment date and time.

FAX TO 604.708.0748

Date: _____

Referring Physician Information

Name: _____

MSP #: _____

FAX: _____

OR PHYSICIAN STAMP

Patient Information:

Name:_____ Address:_____

PHN:_____ _____

DOB:_____ **Tel:** Home: _____

OR AFFIX LABEL Cell: _____

Email: _____

OBSTETRICS – May select more than one and clinic will book with earliest available physician.					
☐	**Dr. Michelle Bélanger** BC Women's Hospital	☐	**Dr. Julie van Schalkwyk** BC Women's Hospital		
☐	**Dr. Nadia Branco** BC Women's Hospital	☐	**Dr. Jenise Yue** BC Women's Hospital		
☐	**Dr. Monica Brunner** BC Women's Hospital	☐	**Dr. Jennifer Yam** St. Paul's Hospital	☐	**URGENT REFERRAL** **Patient will be seen within 2 weeks**, with soonest available OB, if selected provider unable to accommodate time frame.
☐	**Dr. Salim Lalani** Burnaby General Hospital	☐	**Dr. Angel Shan** Surrey Memorial Hospital		

LMP = 20___ /_____ /_____
Year Month Day

EDC = 20___ /_____ /_____
Year Month Day

Reason for Referral						**Supporting Documents**	**Attached**	**To Follow**
☐	Complete Prenatal Care	☐	Shared Prenatal Care	☐	Consultation Only	AN I & II	☐	☐
						PN Labs	☐	☐
						Ultrasound	☐	☐
						PAP	☐	☐
						Other	☐	☐

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