**BURNABY MATERNITY CLINIC**
1st Floor, Burnaby Hospital
3935 Kincaid Street, Burnaby, BC V5G 2X6
Phone: (604) 431-2822 Fax: (604) 412-6646

# Referral Form

**Date of Referral:** _____ **Patient Self Referral** ☐

**Patient's Name:** _____ (Last) _____ (Middle) _____ (First)

**Date of Birth:** _____ (Month / Day / Year) **PHN:** _____

**Address:** _____

_____ (City) _____ (Province) _____ (Postal Code)

**Phone:** _____ (Home) _____ (Work) _____ (Other)

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**Referring Physician:** _____ **Billing No.:** _____

**Phone:** _____ **Fax:** _____

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**G** ___ **T** ___ **P** ___ **A** ___ **L** ___ **LMP:** _____ **EDD:** By Dates _____
By Ultrasound _____

**Obstetrical History** **Significant Medical Problems**

_____ _____
_____ _____
_____ _____
_____ _____

**Please FAX the following documentations with this referral:**

| | | | |
|---|---|---|---|
| **Prenatal Records Parts 1 & 2** | **Yes** ☐ | **No** ☐ | **Pending** ☐ |
| **Prenatal Bloodwork (including Triple Screen)** | **Yes** ☐ | **No** ☐ | **Pending** ☐ |
| **Ultrasound Reports** | **Yes** ☐ | **No** ☐ | **Pending** ☐ |

**Additional Comments:** _____

**(For Clinic Use only)**

**Doctor:** _____

**Date of Appointment:** _____ **Time:** _____

**Additional Comments:** _____

_____

**No Show (reason):** _____