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JPOCSC Maternity Clinics: POSTPARTUM CONTRACEPTION AND IUD CLINIC REFERRAL

Form ID: MSXX106766A New: July 17/16 Page: 1 of 1

JPOCSC Maternity Clinics 9750 140 Street, Surrey BC V3T 09G **Phone: (604) 582-4550 Ext 763992 Fax: (604) 582-3775**

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

Patient's Full Legal Name: _____ (Last) _____ (First) _____ (Middle)

Other Name(s) (if applicable): _____

Personal Health Number: _____ Date of Birth: _____/_____/_____ (DAY/MONTH/YEAR)

Address: _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Home Phone No. _____ **Cell Phone No:** _____

Emergency Contact/Next of Kin: _____ **Phone Number:** _____

Insurance Type: ☐ MSP ☐ WCB ☐ Out-of-Province ☐ Self-Pay ☐ Other: _____ RCMP or Armed forces#: _____

Interpreter Required: ☐ **No** ☐ **Yes** **Language:** _____

Reason for Referral:

☐ Postpartum contraception and intrauterine device counseling

☐ IUD insertion only: Insertions include PAP (if applicable) and STI screening

Delivery Information:

G ___ P ___ T ___ A ___ L ___

Date: _____

Type of Birth: _____

Patient Medical History:

☐ Active malignancy
☐ Unexplained vaginal bleeding
☐ History of breast cancer
☐ Seizure disorder on anticonvulsants
☐ Active pelvic inflammatory Disease
☐ Known anatomic abnormalities
☐ Current breast disease
☐ Fibroids
☐ History of thromboembolic event
☐ Migraine headaches
☐ Hypertension
☐ Other (please specify): _____

Current Medications:

_____

_____

Allergies:

_____

_____

Please ensure the following are attached to this referral form:

☐ Antenatal records (if available) ☐ Most recent PAP report ☐ Labour and delivery records

Family Physician (if different from referring provider)

Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ Patient has no GP/NP

Referring Health Care Provider:

Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ GP ☐ Ob/Gyne ☐ NP ☐ MW ☐ Other

Referring Practitioner Signature: _____ **Date of Referral:** _____