



fraserhealth

**NAUSEA AND VOMITING IN PREGNANCY CLINIC REFERRAL
JIM PATTISON OUTPATIENT CARE AND SURGERY CENTRE**



MSXX104478A

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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:** ____/____/____
(DD, MM, YYYY)

Address: _____
Street City Province Postal Code

Home Phone No. _____ Okay to Call **Message Phone No.** _____

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

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

Age at referral:		Age at EDC:		Pre-registered at: SMH <input type="checkbox"/> LMH <input type="checkbox"/> PAH <input type="checkbox"/> Other <input type="checkbox"/>	
LMP: (DD/MM/YY)		Circle which is the final EDC		Date of earliest ultrasound: (DD/MM/YY)	
Regular cycle?		EDC by LMP: (DD/MM/YY)	EDC by U/S: (DD/MM/YY)	Gestational age at earliest ultrasound	
G	T	P	SA	TA	L
				Multiple gestation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other	

Criteria for Referral to Nausea & Vomiting in Pregnancy Clinic: (Patient may self refer)

- History of excessive nausea and vomiting
Accompanied by: Signs and symptoms of dehydration
 Weight loss (7-8 lbs/3kg)
- No underlying health condition that contraindicated rapid IV infusion

- Patient has been started on Diclectin 4 tabs/day: Yes No
- Preprinted orders for NVP completed and signed
- Dating Ultrasound Done: Yes No If U/S not done is one booked: Yes No

Additional Comments:

THE FOLLOWING RECORDS MUST BE RECEIVED TO PROCESS THIS REFERRAL

- Antenatal Record Part I and Part II (If started)
- Reports of all ultrasounds done in this pregnancy
- All available lab results; including serum integrated prenatal screen results, blood group and screen, CBC, prenatal screen, PAP smear results, FBS 2 hour OGTT (where indicated), A1C (within 3 months), electrolytes (if applicable, i.e. NVP), vaginal swabs
- All consultation reports and investigational records related to maternal diagnosis

Family Physician (if different from referring source)

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

Referring Health Care Provider:

Name: _____
MSP #: _____
Phone: _____ Fax: _____
 GP Specialist NP Hospitalist ER Other

Printshop # 261987

Referring Physician Signature: _____