

Prenatal and Maternity Clinic
Fraser Clinic

 6184 Fraser Street
 Vancouver, BC V5W 3A1

Phone: 604-301-9955 / **Fax:** 604-301-1566

Email: info@pacificmedicalvancouver.com
Grandview Clinic

 3185 Grandview Hwy
 Vancouver, BC V5M 2E9

Phone: 604-434-2222 / **Fax:** 604-434-2220

Email: info@pacificmedicalvancouver.com
REFERRAL FORM

Date:	Patient Name:		
Referring Physician:		DOB:	PHN:
MSP:	Address:		
Clinic Phone:	Clinic Fax:	Home Phone:	Cell:

MATERNITY CARE REFERRAL
IUD REFERRAL

- G _____ P _____ A _____
- LMP _____
- Medical Issues _____

- Copper (Liberte)
- Hormonal
 - Kyleena
 - Mirena

Urgency of Referral: Urgent [within 1 week] Semi-urgent [within 1- 2 weeks] Routine

Clinical Questions:

Please include **labs, imaging, other diagnostic reports and relevant medical information** with the referral form. Please note that any incomplete referrals will be returned for completion. A confirmation of referral will be sent to your office. The patient will be contacted for scheduling.

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THANK YOU FOR THE REFERRAL