Adult Bleeding Disorders Program of BC
St. Paul's Hospital
1081 Burrard Street, West Burrard Building, Room 491
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Date of Referral: _____

Instructions for referring office:

1. All referrals must be completed on this form.
2. Provide as much detail as possible to ensure patient can be triaged quickly and appropriately.
3. Send all relevant investigations and reports from previous years. Note: Incomplete referral packages will not be processed.

PATIENT INFORMATION

Surname:	Given name:	Preferred name:
DOB: Month/Day/Year	Gender: ☐ Male ☐ Female ☐ Other	
Address:	Email address:	
Telephone #: (home):	cell:	work:
Health Card Number:		
Interpreter needed: ☐ Yes (specify language) _____		☐ No

PROVIDER INFORMATION

Referring Provider:	MSP#
Telephone #:	Fax #:
Address:	
Was this patient seen by a hematologist in the past: ☐ Yes (Name:) ☐ No	☐ Unknown

REASON FOR REFERRAL

☐ Family History of Bleeding Disorders:

☐ Suspected Diagnosis:

Comments:

Fax all referrals to 604-806-8784