



Adult Bleeding Disorders Program of BC

St. Paul's Hospital

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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: <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Other
Address:		Email address:
Telephone #: (home):	cell:	work:
Health Card Number:		
Interpreter needed: <input type="checkbox"/> Yes (specify language) _____		<input type="checkbox"/> No

PROVIDER INFORMATION

Referring Provider:	MSP#
Telephone #:	Fax #:
Address:	
Was this patient seen by a hematologist in the past: <input type="checkbox"/> Yes (Name: _____) <input type="checkbox"/> No <input type="checkbox"/> Unknown	

REASON FOR REFERRAL

<input type="checkbox"/> Family History of Bleeding Disorders: _____ _____	
<input type="checkbox"/> Suspected Diagnosis: _____ _____	
Comments: _____ _____ _____ _____ _____	

Fax all referrals to 604-806-8784