Providence Health Care

SPH WOMEN'S ENDOCRINE HEALTH CENTRE REFERRAL FORM

Place Patient Label Here

St. Paul's Hospital Women's Endocrine Health Centre
1081 Burrard Street, Vancouver, BC V6Z 1Y6
Phone: 604-806-9606

Date of Referral: (dd/mmm/yyyy) _____

PATIENT INFORMATION (please print clearly)		
Last name:	First name:	
Date of birth: (dd/mmm/yyyy)	PHN:	Sex assigned at birth:
Gender identity: ☐ Male ☐ Female ☐ Non-binary ☐ Other: _____	Pronouns used:	
Patient address:		Patient email: ☐ Permission to email patient
Patient phone:	Alternate phone:	Interpreter Required: ☐ No ☐ Yes Language: _____
Is this patient pregnant or pursuing pregnancy? ☐ No ☐ Yes		
Does this patient have any special needs? ☐ No ☐ Yes If yes, please specify: _____		

PROVIDER INFORMATION		
Referring Provider:		Billing number:
Office address:		
Office phone:	Office fax:	Office email:
Primary Care Provider:		Billing number:
Office address:		
Office phone:	Office fax:	Office email:

URGENCY

For same-day advice, please contact RACE through the app or visit the website http://www.raceconnect.ca/ if you don't have app access

☐ Non-Urgent
☐ Urgent: Reason _____

Has this patient been seen by a St. Paul's Hospital Women's Health Specialist before? ☐ No ☐ Yes
Name: _____ Date: (dd/mmm/yyyy) _____
Is this a Re-referral? ☐ No ☐ Yes

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SYMPTOMS OF / SUSPECTED DIAGNOSIS OF

- ☐ Polycystic ovarian syndrome
- ☐ Premature ovarian insufficiency
- ☐ Gonadal dysgenesis (e.g. Turner Syndrome)
- ☐ Transgender care
- ☐ Endocrine complications in pregnancy (e.g. thyroid disease, calcium disorders)
- ☐ Hyperandrogenism
- ☐ Menstrual irregularity or amenorrhea
- ☐ Reproductive genetic abnormalities (e.g. congenital adrenal hyperplasia)
- ☐ Other: _____

Reason for Referral:

FOR OFFICE USE ONLY

Acknowledgement of referral (to be completed within 5 business days)

Our office will make an appointment with your patient within the next_____ ☐ days or ☐ weeks)

Your patient is booked to see a specialist on: Date: (dd/mmm/yyyy) _____Time: _____

☐ We will notify your patient of the above appointment

☐ Please notify your patient of the above appointment

☐ We require the following additional information before we can book an appointment for this patient:

_____

_____

_____

_____

_____

*** To ensure prompt booking, please ensure all sections are fully completed ***

Please include medication list and any imaging or consult notes NOT accessible on CareConnect.

SCAN / EMAIL COMPLETED REFERRAL TO: endoclinics@providencehealth.bc.ca

OR FAX COMPLETED REFERRAL TO: 604-806-9618

Provider Signature: _____ Date: (dd/mmm/yyyy) _____