Providence HEALTH CARE

CARDIAC OBSTETRICS CLINIC REFERRAL

Obstetrics Referral

Date of Referral: ______________________

FOR URGENT REQUESTS (including referrals more than 36 weeks gestation) **contact VPACH physician on call (604-682-2344)**

PATIENT INFORMATION		
Name: (last, first)		**Telephone:** Home: ______ Work: ______ Cell: ______
Former name/maiden name:		
Address:		
City:	Postal Code:	
DOB: (dd/mmm/yyyy)	PHN:	☐ Interpreter required Language: ______
Alternative contact: (name)		
Relationship to patient:	Telephone:	
If pregnant, estimated date of delivery:		

REASON FOR REFERRAL

☐ Congenital Heart Disease: ______________________

☐ Acquired Heart Disease: ______________________

☐ Pre pregnancy counseling: ______________________

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☐ Symptomatic arrhythmias: ______________________

☐ Other cardiac condition: ______________________

Symptoms: (details) ______________________

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REFERRING CLINICIAN		
Name:	Specialty:	MSP number:
Address:		
Telephone:	Fax:	

PRIMARY OBSTETRIC CARE PROVIDER	
Name:	MSP number:
Address:	
Telephone:	Fax:

COMPLETED TESTS and ASSESSMENTS (please attach copies):

☐ Cardiac Echocardiogram	☐ ECG	☐ Holter Monitor
☐ Obstetrical Echocardiogram	☐ Fetal Echocardiogram	☐ Antenatal records

OTHER RELEVANT INFORMATION

MEDICATIONS: ______________________

ALLERGIES: ______________________

OTHER: ______________________

Please refer early to allow time to plan and organize care.

Newly diagnosed murmurs must have echo imaging completed prior to referral.

PLEASE FAX INFORMATION TO: **Cardiac Obstetrics Clinic (COB)** St. Paul's Hospital **Fax: 604-602-8643**

5051-1081 Burrard St, Vancouver, BC V6Z 1Y6

Telephone: 604-806-8520 Ext. 5 Email: SPHCOB@providencehealth.bc.ca