**Physicians:**

☐ Dr. Chelsea Elwood ☐ Dr. Hanna Ezzat ☐ Dr. Brigid Dineley

☐ Dr. Stephanie Fisher ☐ Dr. Stephanie Rhone

Referring MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MSP#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place stamp here

Affix label here

* **Urgent referral: patient will be seen within 1-2 weeks**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your office will be informed of appointment details by fax.

Please fax referrals to

604 – 875-8099

**Gynecologic referral**

Reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accompanying information

* Ultrasound
* Labs
* Pap smear

**Obstetrical referral**

Confirmed EDC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Complete care
* Shared care
* Consultation only