BC Children's Hospital
An agency of the Provincial Health Services Authority

Division of Pediatric Hematology/Oncology/Blood & Marrow Transplant

Dr. Caron Strahlendorf, MBBCh, FCP, FRCPC
Division Head

Ali Amid MD, FRCPC | Mark Belletrutti MD, MSc, FRCPC | Sylvia Cheng MD, FRCPC, FAAP | Natasha Datoo MD, FRCP(C) | Rebecca J. Deyell MD MHSc FRCP(C) FAAP | David B. Dix MBChB, FRCP(C), FAAP | Jessica Halparin MD, FRCP(C)

Melissa Harvey MD, FRCP(C) | Juliette Hukin MBBS, FRCP(C), FAAP | Amanda M. Li MD, MSc, FRCP(C) | George Michaiel MD, FRCPC, FAAP | S Rod Rassekh MD MHSc FRCP(C) FAAP | Meera Rayar MD, FRCPC, FAAP | Jacob Rozmus MD, PhD, FRCP(C) | Kirk R. Schultz MD, FCAHS

Pediatric Hematology Patient Referral Form

Thank you for your referral. Please complete all the information below, attach all relevant clinical and lab reports **and fax to us at 604-875-2911**. Incomplete referrals will be returned for further information.

For urgent referrals please page the on-call Hematologist via BC Children's Hospital (604-875-2161) to discuss the case. All other referrals will be triaged by the Hematologist on-service according to urgency and a response letter will be sent.

Patient Name: _____ **Date of Referral**: _____

Patient PHN: _____ **Referring Physician**: _____

DOB: _____ ☐ **M** ☐ **F** **Referring Physician Phone**: _____

Parents/Guardians: _____ **Primary Care Provider**: _____

Mailing Address: _____

_____

Phone: _____

Email: _____

Reason for Referral *(Please clearly state your clinical question or concern):*

_____

_____

Relevant Past Medical History:

_____

_____

Has the patient been seen previously by a Hematologist at BC Children's Hospital?

☐ **Y** ☐ **N** **If yes, Name**: _____

If your office does not receive a referral response within 2 weeks please call 604-875-2406 to confirm receipt of the referral.