General Orthopedics Referral Form

Orthopaedics: Tel: 604 875 2345 ext 3187 / Fax: 604 875 2275
http://www.bcchildrens.ca/our-services/clinics/orthopaedics

Please Complete: Internal CST Referral External Referral

Section 1: Patient Demographics

This section must be completed for all requests.

Patient Name:
Surname First Name Initial

Phone (Home):

Address:

Phone (Work):

City: Postal Code:

Phone (Cell):

PHN: Birthdate: Sex:

Does patient speak/understand English? Yes No If no, language spoken:

If no, please provide an alternate contact (name): Alternate Contact No.

Referring Provider: MSP ID: Phone: Fax:

Primary Care Physician: (if different from above) MSP ID: Phone: Fax:

Section 2: Relevant History & Examination Findings

Is patient experiencing pain? None Mild Moderate Severe

Section 3: Relevant Past Medical History/Family History

Section 4: Referral Priority

Referral Priority: Routine Urgent Reason for urgent referral:

Referral To:

Section 5: Primary Diagnosis

Diagnosis Category:

Diagnosis Description:

Priority Code:

Target Time for Appointment:

Required X-ray :

Are the required X-rays available for assessment? Yes No Not Applicable

These targets are for intended scheduling purposes, we strive to achieve these times but wait time often exceeds these targets and we do not guarantee that we can see patient in this window.

ADDITIONAL PATIENT INFORMATION

Physician/Referring Provider Signature: Date:

General Orthopaedics Referral Form Instructions

DO NOT FAX THIS SIDE when referring patients to BCCH. This is an Informational page for your use. Please Note: Referrals can not be processed unless all information is complete.

Section 1: Patient Demographics

Complete patient demographics and referring physician/provider information:

Section 2: Relevant History & Examination Findings

It is an open-ended text box designed for documenting any relevant history and findings obtained from a variety of diagnostic tests. This may include results from X-rays, MRIs, or other medical devices. This space allows for detailed notes and observations that are crucial for comprehensive medical records. Additionally, describe the patient's current pain experience, which is crucial for accurate diagnosis and treatment planning.

Section 3: Relevant Past Medical History/Family History

Complete this section if the patient has relevant past medical or family history.

If there is relevant medical history for the patient or their family, ensuring that significant health background information is recorded.

Section 4: Referral Priority

This section outlines the priority of the referral, indicating whether it is an urgent or routine case. If the referral is marked as urgent, a reason must be provided to justify the priority. This ensures that the urgency is well-documented and supported by relevant information.

Section 5: Primary Diagnosis

This section outlines the patient's primary diagnosis, which includes the diagnosis category and it description. The user only select the "Diagnosis Category" and its corresponding "Diagnosis Description", while the fields "Priority Code", "Target Time for Appointment", and "Required X-ray" will be auto-populated and these fields are non-editable.
If required X-rays are not attached referral will be refused and returned.

BCCH Clinics - Contact Information

Choose which Clinic your patient wants to attend. If the chosen clinic is not available within set time frame patient will be given the option to attend an alternate clinic.

BCCH Vancouver **Fax: 604 875 2275** **Phone: 604 875 2345 ext 3187**

*** New Referral Forms available on the BCHHR website at http://www.bcchildrens.ca/health-professionals/refer-a-patient/orthopaedics-referral or by calling 604 875 2345 ext 3187.**

For more information, please call the BCCH at 604 875 2345 ext 3187 or visit http://www.bcchildrens.ca/