island health

PPID Label

Antenatal Assessment Unit (AAU) Referral Form

Fax: 250-727-4441

IMPORTANT

Please note Referral Forms will not be triaged if they do not have a recent Antenatal Record, accompanied by any pertinent bloodwork, or additional reports (operative, EPAU / WCMI) from outside sources attached.

Date of Referral: _____
Patient Name: _____
Date of Birth: _____
Phone #: _____
Address: _____
_____
PHN: _____
Referring MRP: _____
Billing Number: _____
Clinic Phone #: _____
Clinic Fax #: _____

Reason for Referral:

_____

EDC: _____
Gest Age at time of Referral: _____

Clinic Needed:

☐ Nursing ☐ MFM ☐ OB
☐ Anesthetic ☐ Complex Care
☐ Pre Conception
☐ *Urgent *(*to be seen within 48 hours - must call OB on call).* ***FAX INFORMATION AS INSTRUCTED BY OB.***

Appt. Date & Time:

Relevant Information: **(**Please add any relevant/pertinent information to assist triaging. ***This replaces need for consult letter*****.)**

Physician Signature: _____

This information is collected under the Hospital Act and Regulations for the purpose of patient care encounter creation and management.

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