

**ST. PAUL'S MATERNITY CARE (SPMC)
CLINIC SELF-REFERRAL FORM**


Obstetrics Referral

 Location: Room 541A – 5th Floor, Burrard Building,
1081 Burrard Street, Vancouver, BC V6Z 1Y6

 Tel: 604-806-9342 Fax: 604-639-8506
Email: maternityclinic@phc.ca

This clinic is only for patients planning to deliver at St. Paul's Hospital. If you have already been referred to an obstetrician, midwife or other family doctor for pregnancy care, do not submit this referral form.

- I understand that SPMC is a collaborative care team, with both midwives and family doctors as part of an on-call group.
- I understand and agree to have all my pregnancy, delivery care, postpartum, and newborn care with a group of family doctors and midwives.
- I am having a singleton pregnancy.

For twin pregnancies, please get a referral to an obstetrician.

PATIENT INFORMATION (Please complete all fields)		
Last Name:	Legal First Name: Preferred Name:	Do you identify as Indigenous? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> First Nation <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> Unknown <input type="checkbox"/> Other:
Date of Birth:	Email:	Phone Number:
Address:	City:	Postal Code:
Personal Health Number:	Is your provincial health coverage active? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered no, when is it expected to be activated?	If you have no MSP, please provide applicable Interim Federal Health Program (IFPH): If you have no MSP, are you planning to self-pay? <input type="checkbox"/> Yes <input type="checkbox"/> No

REFERRAL INFORMATION (Please complete all fields)		
Today's Date:	Do you have a family doctor or nurse practitioner: <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the name of your family doctor or nurse practitioner?
Language: Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been seen by a doctor or nurse practitioner for this pregnancy? <input type="checkbox"/> Yes: Name of provider/clinic: <input type="checkbox"/> No	Have you had an ultrasound during this pregnancy? <input type="checkbox"/> Yes, Name of clinic: <input type="checkbox"/> No
	First day of your last period:	Confirmed due date by ultrasound:

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Past Medical History:	List all medications you take:	How many total pregnancies have you had? Any previous caesarean births? Any other past pregnancy complications?
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Check and answer the following conditions that apply to you:

Pre-pregnancy diabetes

Describe/Medication:

Pre-pregnancy high blood pressure

Describe/Medication:

Previous high-risk complication in pregnancy

Describe/Medication:

Pre-existing medical conditions (autoimmune, heart disease, etc.)

Describe:

**Please send all bloodwork results and pregnancy ultrasounds to the clinic with your referral form.
You can expect to hear back from us within 1 to 2 weeks and to be seen in the clinic starting around 10 to 12 weeks of gestation**