LEUKEMIA / BONE MARROW TRANSPLANTATION PROGRAM OF BC
NEW PATIENT REFERRAL FORM

*** = Required Information**

***Referral Date:** ____________________ **Person Requesting (office use):** ____________

VGH Chart # ____________ **BCCA Chart #** ____________ **BCCH Chart #** ____________

***LAST Name:** ______________________________ **Title:** ____________

***FIRST Name:** ______________________________ **Initial:** ________ ***Sex:** ______

***D.O.B.:** ______________ ***Medical Ins. (PHN#) :** ____________________

***Address:** ______________________________ ***Home #:** ______________

______________________________ ***Work #:** ______________

Postal Code: ______________________________ ***Cell #:** ______________

Email address: ______________________________

***Referral Diagnosis (if known):** ____

Next of Kin: ____

(FOR DONOR ONLY) Recipient: ____________________ **Relationship:** ____________________

***Family Physician:** ______________________________ **Billing#:** ______________

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______________________________ **Telephone:** ______________

Postal Code: ______________________________ **Fax:** ______________

***Referring Physician:** ______________________________ **Billing#:** ______________

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______________________________ **Telephone:** ______________

Postal Code: ______________________________ **Fax:** ______________

~ *FOR OFFICE USE ONLY* ~

PATIENT TO BE:
- ☐ seen immediately *(Triage physician to process)*
- ☐ seen within coming week *(Return to Shawna Moore)*
- ☐ seen in next 2 weeks *(Return to Shawna Moore)*
- ☐ seen > 2 weeks *(Return to Shawna Moore)*

CHART
- ☐ Regular Soft Chart
- ☐ Regular Donor Chart
- ☐ Unrelated Donor Search Chart
- ☐ Unrelated Donor Chart

CLINIC
- ☐ VGH Leukemia/BMT Clinic
- ☐ MDS
- ☐ Outreach – Kelowna
- ☐ Outreach – Prince George
- ☐ Outreach – Abbotsford
- ☐ Outreach – Victoria

Triage Physician: ____________________ **Signature:** ____________________

Referred to: ____________________ **Appt. Date:** ____________________