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OBSTETRICS & GYNAECOLOGY

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REFERRAL REQUEST

Fax this form with labs/reports to: 604-872-1261

*Check neither if no preference and for first available appointment

Dr. Fitzsimmons Dr. Selke

Date: _____ / _____ / _____

Patients Name: _____

DOB: _____ / _____ / _____ PHN: _____

Patient Contact Telephone: (_____) _____ - _____

URGENCY? WITHIN:

*We cannot guarantee these timelines, but will do our best

- 1 week (ie. OB urgent referrals)
- 2 weeks (ie. New OB/ urgent gyne)
- 4 weeks (ie. Menorrhagia - stable)
- 8 weeks
- ≥12 weeks (infertility)

Reason for referral: _____

Please send copies of any relevant and recent labs, including ultrasounds & pap smear.
 For new prenatal referrals please arrange for prenatal bloodwork and genetic testing
 prior to referral.

Referring MD/ Midwife: _____ MSP: _____

Phone:(_____) _____ - _____ Fax:(_____) _____ - _____

***Appointment notification will be faxed to your office; Please inform your patient of the booked appointment time.