Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PRENATAL REFERRAL FORM

❑ Healthiest Babies Possible Prenatal Program
❑ Youth Pregnancy & Parenting Program (up to 22 years)

Vancouver/Richmond Fax to: 604-253-1925

PHN: _____ PARIS ID:_____

Last Name**:**_____

First Name: _____ Middle: _____

Address:_____

_____

Postal Code: _____ CHC:_____

Telephone:_____ ❑ ok to leave msg

Cell: _____ ❑ ok to leave msg

Email: _____

Other contact person: _____

_____

Date of Referral: _____

Referrer's Name/Role: _____

Referral Phone:_____

Family Doctor: _____

Delivering Doctor/Midwife:_____

Clinic Address: _____ Phone: _____

Due Date: _____ Weeks Gest: _____

Birthdate:_____ Age:_____

Ages of children:_____

Country of Origin: _____ Ethnicity: _____

Language:_____ English: ❑ Fluent ❑ Basic

MEDICAL / SOCIAL HISTORY
"How can we help (or support) you?"

PLEASE SPECIFY REASON FOR REFERRAL

Low income (Do you have enough for basics like rent and food?)	❑	BMI or weight gain concerns	❑
Social isolation (Do you have friends or family you can talk to?)	❑	Inadequate nutrition	❑
First Nations	❑	Mental health	❑
Recent immigrant (< 2yrs)	❑	Smoking	❑
Single parent	❑	Substance Use	❑
Not completed high school	❑	Abuse	❑
Age 22 or under*	❑	Other: _____	❑

*For YPPP, attach antenatal record, all blood work and ultrasound report

OFFICE USE ONLY

HBP #_____ PARIS ID:_____ HBP Staff: _____ Date: _____

YPPP only: Telephone Contacts: _____ EMR Appt booked:_____