VGH UPAC Referral Form

Please fax at **250-727-4211.**

☐ **Urgent Referral (Patient to be seen within 48 hr)**
All urgent referrals MUST BE APPROVED by the On-Call Pediatrician at VGH
Call VGH Switchboard at 250-727-4212 to contact On-Call Pediatrician
Name of On-Call Pediatrician:
☐ **Non-Urgent Referral (Patient will be triaged to be seen within 1 month)**

Date of Referral:

Referring Physician/Nurse Practitioner/Midwife:	Billing number:
Family Physician/Nurse Practitioner/Midwife:	Pediatrician:

Patient Information (Name, DOB and PHN):

Name of the parent/legal guardian/caregiver:
Phone number:

Please ensure this is **fully completed**:
☐ This patient needs to be seen **within 1 month**.
☐ This patient does not have a **Family physician or Nurse practitioner** that would be appropriate for follow-up.
☐ If the patient **has a Pediatrician**, please forward the referral to their office **unless urgent assessment is required within 2 weeks. Please also forward a copy of the referral to the pediatrician's office indicating that a referral to UPAC has been made.**
☐ The patient does not meet any exclusion criteria:
- Behavior, school or learning challenges
- Child Abuse
- Chronic problem (eg. headache/abdominal pain/pain > 8 weeks)
- Developmental Delay
- Eating disorders
- Infectious gastrointestinal illness
- Mental Health
- Substance use

☐ **If repeat investigations (e.g., blood work) are required, please provide the family with the requisition** and ask them to complete the tests at least one day before their scheduled UPAC appointment.

Reason for referral:

UPAC CLINIC ONLY

☐ Consultation ☐ Hospital follow-up ☐ UPAC follow-up	Diagnosis: Precautions required: ☐ Yes ☐ No	☐ Date: _____ ☐ 1-2 days ☐ next week ☐ this week ☐ 2-4 weeks	**Booking Clerk:**