Vancouver CoastalHealth

UBC Hospital

Bladder Care Referral

UBC Bladder Care Centre
UBC Hospital Koerner Pavilion
Unit 1B 2211 Wesbrook Mall Vancouver, BC V6T 2B5
Tel: 604.822.6143 Fax: 604.822.6984
www.vch.ca/BladderCareCentre

Patient Label

Please print clearly.

1. Patient Name:_____ ☐ F ☐ M Pronouns:_____

   DOB:_____ PHN:_____

   Address: (Home):_____ Tel#: Cell:_____ Home:_____

   Email address:_____

   (Facility name):_____ Transport: ☐ SNT / Ambulance booked

   Referring Physician:_____ Tel:_____ Fax:_____ Bill#:_____

   Family Physician:_____

   Is this visit due to a: WCB Claim: ☐ Yes ☐ No Claim#:_____

   ICBC Claim: ☐ Yes ☐ No Claim#:_____

2. **Please refer this patient to** (check ✓ one of the following)**:**

   ☐ Dr. Mark Nigro ☐ Dr. Christina Poon ☐ Dr. Daniel Rappoport ☐ Dr. David Wilkie ☐ Dr. Jennie Mickelson

   ☐ Dr. Alex Kavanagh ☐ Dr. Kate Anderson ☐ Dr. Henry Tran ☐ First available ☐ Dr. _____

3. **Exam requested** (check ✓ all required exams needed)**:**

☐ Flow rate and bladder scan	☐ CIC teaching (please indicate below instructions for CIC)
☐ Urodynamics	
☐ Cystoscopy	
☐ Sacral Neuromodulation consult	
☐ Video Urodynamics	☐ PTNS (user fee)
☐ NCA	☐ Pessary fitting (user fee)
☐ Pelvic Floor Physiotherapy : Bladder Care Center	☐ Bladder Installation Other:
☐ Pelvic Floor Physiotherapy : Gender Surgery Program Please indicate ☐ Pre-op ☐ Post op ☐ Revision Does this patient live outside the Lower Mainland? Referring physician report(s) attached:	Surgical Date (if available): _____ ☐ Yes ☐ No ☐ Yes ☐ No Reason: _____

4. **PATIENT HISTORY MUST INCLUDE: CONSULTS, LAB AND DIAGNOSTIC RESULTS.**
   FAILURE TO COMPLETE PROPERLY WILL RESULT IN REFERRAL BEING RETURNED.

   Latex Allergy: ☐ Yes ☐ No ☐ Consult and other History enclosed

   _____

   _____

   _____

   _____

   Supra-pubic catheter: ☐ Yes ☐ No Indwelling catheter: ☐ Yes ☐ No Self-catheterize: ☐ Yes ☐ No

   Disabilities: ☐ Yes ☐ No Specify:_____

   Mobility Aid: ☐ Yes ☐ No (wheelchair / walker / cane / crutches)

   Ceiling Lift: ☐ Yes ☐ No Patient weight:_____

   Interpreter Needed: ☐ Yes ☐ No Language:_____