PULMONARY HYPERTENSION CLINIC / PROGRAM
7th Floor, Room#7250 – Diamond Centre
2775 Laurel Street
Vancouver, BC V5Z 1M9

Telephone: 604-875-4323
Fax Requisition: 604-875-4210

PULMONARY HYPERTENSION CLINIC REFERRAL

PLEASE PRINT CLEARLY ☐ ALLERGIES (PLEASE LIST):

Please indicate referral request type:

☐Emergent (referring physician must contact PH clinic staff or physician directly for emergent referrals)

☐Urgent (2-8 weeks) Reason: _____

☐Routine (8-12 weeks)

BILLABLE TO: ☐ MSP ☐ ICBC ☐ WCB ☐ PATIENT ☐ OTHER	NAME / ADDRESS OF REFERRING PHYSICIAN AND MSP PRACTITIONER # (or office stamp)
PERSONAL HEALTH NUMBER: / DOB: YYYY/MM/DD	
SURNAME OF PATIENT, FIRST NAME AND MIDDLE INITIAL	
TELEPHONE# (INCLUDE AREA CODE): / ☐ MALE ☐ FEMALE PREGNANT: ☐ YES ☐ NO	
ADDRESS CITY/TOWN POSTAL CODE	COPY RESULTS TO:

☐ TRANSLATION SERVICES REQUIRED: (PLEASE INDICATE LANGUAGE) _____
(24 HOUR ADVANCED NOTICE REQUIRED)

PERTINENT HISTORY

REASON FOR REFERRAL:

_____

_____

_____

_____

_____

INVESTIGATIONS (please indicate if any of these investigations have been completed within the last 2 years):

☐ CXR	DATE:	LOCATION:
☐ ECHO	DATE:	LOCATION:
☐ CT SCAN	DATE:	LOCATION:
☐ PFT'S	DATE:	LOCATION:
☐ V/Q SCAN	DATE:	LOCATION:
☐ BLOOD WORK	DATE:	LOCATION:
☐ OTHER	DATE:	LOCATION:

PLEASE ATTACH ALL RECENT BLOOD/LABORATORY/PERTINENT RESULTS/CURRENT MEDICATIONS

PLEASE NOTE

- **ALL REFERRAL INFORMATION MUST BE COMPLETED IN FULL. INCOMPLETE REFERRALS WILL BE RETURNED TO BE COMPLETED.**

A FEE MAY BE CHARGED TO PATIENTS WHO FAIL TO PROVIDE 24 HOURS NOTICE OF CANCELLATION FOR A SCHEDULED APPOINTMENT OR TEST

OUR FACILITY IS A FRAGRANCE FREE ZONE