Patient Attachment Initiative
T: 604-559-8076
F: 604-428-6969
E: pai@vancouverdivision.com

ALL SECTIONS ON THIS PAGE MUST BE COMPLETED AND FAXED TO 604-428-6969

A. Referral Information	
Referrer name:	Date: (DD/MMM/YYYY)
Site/program/unit:	Referrer phone:
Referrer email:	Referrer fax:
B. Patient Information (patient label is sufficient – please also include email address)	
Full name:	Name used (if different):
PHN:	Date of birth: (DD/MMM/YYYY)
Gender:	Pronouns:
Address, City, Postal Code:	
Phone number(s):	Email:
Interpretation required? Specify language:	Identifies as Indigenous: ◯ Yes ◯ No
C. Alternate Contact (if there are potential communication barriers with patient)	
Full name:	Relation:
Phone number(s):	Email:
D. Patient Consent	
I consent to the terms of service and confirm that I meet the program's eligibility criteria as outlined on page 1:	
Print name:	Signature:
Date: (DD/MMM/YYYY)	◯ Self ◯ Parent/Guardian/Rep ◯ Referrer (if consent obtained verbally)
E. Care Needs	
Care needs are our top consideration when matching patients to providers. **Please attach collateral covering recent, relevant medical history** including diagnoses, current medications, recent or upcoming operations, and any involved care teams or specialists. If these records are not available to you, please write any available information on page 3. Please note the requests for special populations below.	
E-2. For patients in perinatal period	
Est./actual date of delivery: (DD/MMM/YYYY)	- Please include antenatal, labour & birth, and newborn records - Please do not refer until 20 weeks
E-3. For patients with palliative care needs	
Prognosis (if known): ◯ <1 mo ◯ <6 mo ◯ >6 mo	- Please include BCPCB registration and No CPR form if signed
E-4. For patients hospitalized in the last month	
Name of facility/unit(s):	Reason for admission:
Date of admission: (DD/MMM/YYYY)	Est./actual date of discharge: (DD/MMM/YYYY)

Patient Attachment Initiative
T: 604-559-8076
F: 604-428-6969
E: pai@vancouverdivision.com

THIS PAGE MAY BE LEFT BLANK AND OMITTED IF ADEQUATE COLLATERAL IS ATTACHED

E-5. Care Needs cont.

Care needs are our top consideration when matching patients to providers. **Please attach collateral covering recent, relevant medical history** including diagnoses, current medications, recent or upcoming operations, and any involved care teams or specialists. If these records are not available to you, please write in any available information below.

Diagnoses

Current medications

Recent surgical history/upcoming operations

Other care teams, services, or specialists