Pulmonary Hypertension Clinic
Gordon & Leslie Diamond Health Care Centre
2775 Laurel Street
Vancouver, BC V5Z 1M9
7th Floor – Room : 7250
Tel : 604-875-4323
Fax : 604-875-4210
Email :VAPulmonaryHypertensionClinic@vch.ca

** PLEASE PRINT CLEARLY**

PULMONARY HYPERTENSION CLINIC REFERRAL

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): ☐EMAIL: ☐ MALE ☐ FEMALE PREGNANT: ☐YES ☐NO	Family Physician:
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):

☐ ECHO	DATE:	LOCATION:
☐ HEART CATH	DATE:	LOCATION:
☐ CT SCAN	DATE:	LOCATION:
☐ V/Q SCAN	DATE:	LOCATION:
☐ PFTS/ONO	DATE:	LOCATION:
☐ BLOOD WORK	DATE:	LOCATION:
☐ OTHER	DATE:	LOCATION:
☐ ALLERGIES:		

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

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