Vancouver
Division of Family Practice
A GPSC initiative

Please affix patient label (if available)

PATIENT ATTACHMENT INITIATIVE

MOTHER-INFANT DYAD

Patient Referral for Family Doctor Attachment

CRITERIA FOR REFERRAL

--- PLEASE CONFIRM PATIENT ELIGIBLITY BY CHECKING ALL BOXES BELOW ---

Patients who do not meet all of these requirements are not eligible to be matched through this program.

The patient:
- ☐ **is a city of Vancouver resident**
- ☐ **speaks English** (or is able to bring someone who speaks English to appointments)
- ☐ **does not have a family doctor providing continuing care** (eg has not seen family doctor >18 months)
- ☐ **must have active (or pending) MSP coverage**
- ☐ **has relatively stable mental health, medical condition and addiction at time of referral.**
- ☐ **is able to comfortably call to schedule and attend appointments in a medical office.**

PATIENT CONSENT

I, ___________________________________, consent to a summary of the clinical information FOR MYSELF AND MY CHILD being sent to the Vancouver Division of Family Practice Attachment Facilitator (a health care professional) for the purposes of (a): potentially referring my personal health information to a family doctor within the community and (b): recording non-identifying personal health information for the purposes of evaluating the Patient Attachment Initiative. I also understand that the Vancouver Division of Family Practice cannot guarantee a match with a family doctor, and that I may need to continue to search for a family doctor on my own.

--- Please EITHER have patient/decision maker sign consent OR obtain verbal consent ---

Patient/substitute decision maker:______________________________ **Date:**____________
Signature (DD/MM/YYYY)

If substitute decision maker, please state relationship: ______________________________

Verbal consent obtained by:____________________ ____________________ **Date:**____________
Print name Signature (DD/MM/YYYY)

Witness (if substitute/verbal consent): ______________________________ **Date:**____________
Signature (DD/MM/YYYY)

REFERRAL FOR FAMILY DOCTOR ATTACHMENT

Referral requested on:____________________ Expected date of delivery: ____________________
(DD/MM/YYYY) (DD/MM/YYYY)

Referral source: ☐Obstetrician ☐Maternity GP ☐Midwife ☐Public Health Nurse ☐Other: ______________

Name of person referring: ______________________ Practice name:______________________

Practice address: ______________________________________ City: **Vancouver, BC**

Phone number:______________ Fax number:______________ Email:______________________

Primary Medical Reason for Family Doctor Referral: ______________________________

PLEASE FAX THE FOLLOWING PATIENT INFORMATION (WHERE AVAILABLE) WITH THIS REFERRAL FORM

☐ Antenatal Record Part I ☐ Antenatal Record Part II ☐ Labour & Birth Summary ☐ Newborn Record I & II

OR if Public Health Nurse

☐ BC Community Liaison Record (PSBC Form 1591) ☐ Other: ______________________

MOTHER'S INFORMATION

Patient's full name:______________________________________ DOB: ______________
(DD/MM/YYYY)

Address:______________________________ City: **Vancouver, BC** Postal Code: ______________

Phone Number:______________________ Email :______________________________

ADDITIONAL COMMENTS::____

FAX this form and accompanying documents to the Attachment Facilitator at 604-428-6969

Questions? Please contact the Attachment Facilitator at 604-440-7208