# Sexual Health Rehabilitation Service
# Outpatient Referral Form

Blusson Spinal Cord Centre
2nd Floor, 818 West 10th Avenue, Vancouver BC V5Z 1M9
Tel: 604 875 4992 Ext. 1  Fax: 778 504 9739

Date of Referral: _____

Client Information / Label
PHN: _____
Last Name: _____
First Name: _____
Gender: _____ Pronoun(s): _____
Date of Birth: _____ Age: _____
Address: _____
Tel (Home): _____ Tel (Cell): _____
Email: _____

Referring Provider/Clinician: _____
Billing # _____
Tel: _____ Fax: _____
Family Provider: _____

Is the injury work or motor vehicle accident related? Yes/No
If yes, claim organization: _____
If yes, claim number: _____

Medical Status: _____
Allergies: _____
Primary Diagnosis: _____
Date of Onset: _____

Relevant medical/psychological health history: _____

Is the referral of an urgent nature? Yes/No
Reason for Referral: _____