The Midwives Collective
Fax: (250) 483-3826
info@themidwivescollective.ca
107-1120 Yates St, Victoria, BC V8V 3M9

Referral Form

Patient Information

Full Name (pronouns): _____

DOB: _____ PHN: _____

Address: _____

E-mail: _____ Phone: _____

Referring Provider Information

Name: _____

Billing #: _____ Fax: _____ Phone: _____

Reason for Referral Date of Referral:

EDD or Delivery Date: _____

Type of Consult: ☐ Prenatal ☐ Postpartum

Reason(s) for consult: ☐ Incontinence ☐ Birth Preparation ☐ Birth Rehabilitation
☐ Pain (vulvodynia, vaginismus, SPD, pelvic girdle pain, scar tissue, other)
☐ Other: _____

History (if applicable)

Relevant History:

Current Medications:

Additional Information:

☐ Priority Population (IBPOC/Racialized, Newcomer, ESL, Muslim, Multiple Gestation, Single Parent, Socioeconomic Status, Equity-Deserving Group)

Please fax completed referral form and any relevant records to (250) 483-3826
Families will be contacted directly to arrange care
Referrals are covered by MSP prenatally and for up to 6 weeks postpartum

Please refer postpartum clients early, in the spirit of EDI we will make every effort to see all clients who fall within our scope of practice, regardless of MSP coverage