

BC Centre for Sexual Medicine (BCCSM) Referral Form

Blusson Spinal Cord Centre 2nd floor 818 West 10th Avenue Vancouver, BC V5Z 1M9

Phone: 604 875 4705 Fax: 778-504-9746

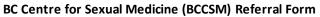
We provide consultation and short-term treatment recommendations for patients with sexual problems including those of interest, arousal, ejaculation, orgasm and/or sexual pain. Therapy is possible in this clinic for some, but not all, sexual concerns.

For medico legal referrals, including ICBC, please contact physicians privately.

Learn more at www.vch.ca/BCCSM.

Referring physician to provide ongoing general care	
FILL FORM COMPLETELY AS REQUIRED BEFORE TRIAGE	

PATIENT NAME(Last)					Female ☐ Male ☐ Other ☐		
	(First)						
	Preferred	pronouns					
Date of birth			(,,,,,,)		PHN #		
	(day)	(month)	(year)				
Patient addre	ess						
City					Postal Code		
Phone: H ()	Cell	()	w ()Local_		
REFERRING D	OCTOR				_ MSP #		
PRIMARY CAR	RE PROVIDE	R			MSP#		
Address							
City					Postal Code		
Phone ()_		Fax	x ()				
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PLEASE CONFIRM (CHECK OFF) ALL BELOW. REQUIRED BEFORE TRIAGE POSSIBLE.

No legal/ ICBC claim ☐ If paraphilia, no Forensic issue ☐ Mental health currently stable ☐ Name of physician supervising mental health
Past sexual abuse: No □, Yes □
If yes, confirmation this has been adequately addressed +/- consults
Type of sexual dysfunction/concern* PLEASE TYPE OR PRINT legibly *
*If ED, does the man have firmer nocturnal (REM sleep) erections? Yes □ No□
If dyspareunia, relevant findings on genital exam
Previous relevant consults, imaging, and labs: No ☐ Yes and are attached ☐
Psychiatric diagnoses and current treatment
Medical conditions and surgeries
Medications
Substance use