a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

DEPARTMENT OF PEDIATRICS
FACULTY OF MEDICINE

BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

Division of Translational Therapeutics Referral Form

Submit to: peds.tt@cfri.ubc.ca

Date of Request: (e.g., March 25, 2013)	**Date Information is Required:** (e.g., April 27, 2013)	
Requestor Information:	☐ Dr. ☐ Mr. ☐ Ms.	
	First Name:	Last Name:
	Title:	Division:
	Mailing Address:	
	City:	Province: / Postal Code:
	Telephone: - - Ext.	Fax: - - / Email:
Purpose of Information:	☐ Policy Decision ☐ Research ☐ Clinical Care ☐ Background Information ☐ Preparation for an Upcoming Meeting ☐ Other:	
Population Age Group:	☐ Fetal ☐ Neonatal ☐ 29 days – 3 month ☐ 3 m – 1 y ☐ 1y – 6y ☐ 7y – 17y ☐ 18y+ ☐ All ages ☐ Other:	

Request Information:

1. Please specify why there is a need to assess this intervention (e.g., potential clinical or non-clinical benefits).
2. Provide information on the patient population, intervention, comparators, and outcome(s).
3. For research related inquiries – what is the research question?
4. For patient related inquiries – please provide clinical scenario and an accurate account of current medications.

Thank you for your referral. All requests are triaged according to urgency, complexity, and personnel availability. A member of the Translational Therapeutics Division will contact you as quickly as possible to discuss your request and ensure it is sufficiently defined so that you receive the best possible information to support your health care and policy decisions.