Burnaby Primary Care Network

MOSAIC
Engaging Newcomers, Enriching Communities

#306 7366 Edmonds St, Burnaby, V3N 1A9
Fax: 604-262-0571 email: communityclinic@mosaicbc.org

Referral to Mosaic Community Clinic (MCC)

Referral Date (mm/dd/yy):	
Referred by (your name):	Organization:
Referrers email:	Referrers work phone:

I confirm that the patient has consented to this referral ☐

Patient is…	yes	no
New to Canada (<3 years)	☐	☐
Unhoused or precariously housed	☐	☐
Experiencing complex mental health	☐	☐
Patient is on extended leave ☐		
A new mom (less than 2 weeks)	☐	☐
Self-identify as First Nations, Inuit, or Metis	☐	☐
Attached to a primary care provider elsewhere in Metro Vancouver	☐	☐

Last Name:	First Name:	Middle Initial(s):
DOB (mm/dd/yy):	Patient is on the Provincial Health Registry Y N	
Gender: M ☐ W ☐ T ☐ Non-B ☐ Other ☐ Unsure☐	Sex as listed on gov't ID: M ☐ F ☐ X ☐	
BC MSP#: IFHP:	☐ other Prov insurance ☐ Private Insurance	☐ Uninsured

Preferred Phone Number:	Email Address:
Secondary Contact Number:	Who's number is this:

I confirm that the patient consents to the clinic leaving a message at this number ☐

Patient's Address: ☐ patient does not have an address	City:	Postal Code:

Patient's primary language(s):

The patient requires services in a language other than English: Y ☐ N ☐	**Language for interpreter:**

Does the patient have a **diagnosed chronic condition** the primary care provider should be aware of: Y ☐ N ☐
If yes, what:

Does the patient have a **disability or accessibility** issue to be considered to facilitate access to the clinic: Y ☐ N ☐
If yes, please elaborate:

What health concerns need to be discussed with the provider at their first appointment? (top 2 concerns)
1. 2.

The patient and/or referrer may be contacted for additional information prior to an appointment