fraserhealth

GENERAL DAY CARE PHYSICIAN REFERRAL
ARHCC

AMXX101581C Rev: March 7/17

Monday to Friday: Fax completed form to GDC Central Booking
(Fax) 604-851-4908 (Ph) 604-851-4700 ext 646788 or 646847

Saturday & Sunday only: Fax completed referral to GDC Unit, Fax: 604-851-4913

It is the responsibility of the referring Physician's office to Inform patient of appointment

PATIENT INFORMATION: ☐ NKA ☐ **ALLERGIES:**	
Surname First Name Middle Name	HEIGHT: WEIGHT:
Address	
Home Phone:	Cell Phone:
DOB:	Age: ☐ F ☐ M
PHN #:	☐ MDRO Positive ☐ MRSA Positive
REFERRING PHYSICIAN: Incomplete referrals will be returned to Physician	MSP Billing #:
Name	Fax #:
Address	Send report to: ☑ Referring Physician ☐ Other (Specify)
REFERRAL CANNOT BE PROCESSED WITHOUT THESE CONTACTS: *Daytime contact #:*	***EVENING/AFTER HOURS CONTACT #:*** ☐ Family practice on-call ☐ Other

PATIENT DIAGNOSIS:

WOUND CARE ORDERS:

REGIONAL PRE-PRINTED ORDERS must be used for the following (available via PetalMD.com):

- Transfusion Medicine
- Anticoagulation treatment program
- Insertion of PICC or Extended-Dwell Peripheral IV
- Parenteral Antibiotic Therapy (Adult)

ADDITIONAL ORDERS:

Medication: _____ Dose: _____ Frequency: _____ Duration: _____

Other:

_____ _____
SIGNATURE DATE