fraserhealth

RAPID ACCESS MEDICINE CLINIC REFERRAL
INTERNAL MEDICINE

FAX to JPOCSC Central Intake (604-953-9701)

PATIENT INFORMATION:

Patient's Name: _____ (Last / First / Middle) **Gender:** _____

Date of Birth: ____/____/____ (DD/MM/YYYY) **PHN:** _____ **Insurance:** _____

Address: _____ (Street / City / Province / Postal Code)

Contact Method **Primary:** _____ **Alternate:** _____

REFERRAL INFORMATION:

Priority: ☐ **Routine** ☐ **Urgent**

Referring Health Care Provider:
Name: _____
Title: _____ **Source:** _____
MSP: _____
Phone: _____ **Fax:** _____

Reason for Referral: _____

Medical Reason for Urgency: _____

Relevant Medical History: _____

Isolation precautions ☐ **Airborne** ☐ **Contact** ☐ **Droplet** ☐ **None**

Interpreter Required ☐ **No** ☐ **Yes** **If yes, specify language** _____

Referral Clinic: **Internal Medicine - Rapid Access Medicine Clinic**

Referring Health Care Provider Signature: _____ **Date:** _____

ADDITIONAL CLINICAL INFORMATION:

When to be Seen:

☐ Urgent (within ____ days)
☐ Specific Date _____
☐ Bloodwork for the past 3 months
☐ Discharge Summary
☐ Diagnostic Testing Report
☐ Specialist Consultation