



**RAPID ACCESS MEDICINE CLINIC REFERRAL
INTERNAL MEDICINE**



MSXX105777B

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

PATIENT INFORMATION:

Patient's Name: _____			Gender: _____
Last	First	Middle	
Date of Birth: _____ / _____ / _____	PHN: _____	Insurance: _____	
(DD/MM/YYYY)			
Address: _____			
Street	City	Province	Postal Code
Contact Method Primary: _____	Alternate: _____		

REFERRAL INFORMATION:

Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent	Referring Health Care Provider: Name: _____ Title: _____ Source: _____ MSP: _____ Phone: _____ Fax: _____
Reason for Referral: _____	

Medical Reason for Urgency: _____	

Relevant Medical History: _____	

Isolation precautions <input type="checkbox"/> Airborne <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> None	
Interpreter Required <input type="checkbox"/> No <input type="checkbox"/> 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:	
<input type="checkbox"/> Urgent (within ____ days)	<input type="checkbox"/> Specific Date _____
<input type="checkbox"/> Bloodwork for the past 3 months	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Diagnostic Testing Report	<input type="checkbox"/> Specialist Consultation

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