



fraserhealth

PRIMARY CARE CLINIC REFERRAL



MSXX104338B

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PAST HISTORY		
Past Medical History	Past Family History	Past Social History

OTHER MEDICAL ISSUES				
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Eye Disease	<input type="checkbox"/> G.I. Problems
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Depression	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dementia
<input type="checkbox"/> Other				

MEDICATIONS (or attach medication record)

ALLERGIES

Family Physician (if different from referring source)	
Name: _____	
MSP #: _____	
Phone: _____	Fax: _____
<input type="checkbox"/> Patient has no GP/NP	

Referring Health Care Provider:	
Name: _____	
MSP #: _____	
Phone: _____	Fax: _____
<input type="checkbox"/> GP <input type="checkbox"/> Specialist <input type="checkbox"/> NP <input type="checkbox"/> Hospitalist	

Referring Physician Signature: _____