fraserhealth

PRIMARY CARE CLINIC REFERRAL

MSXX104338B Rev: Sept. 01/10

JPOCSC 9750 140th Street Surrey, B.C. V3T 0G9 Phone: (604) 582-4585 Fax: (604) 582-4580

Patient's Full Legal Name: _____
Last First Middle

Other Name(s) (if applicable): _____

Personal Health Number: _____ **Date of Birth:** ___/___/___ (DD, MM, YYYY) **Gender: M** ☐ **F** ☐

Address: _____
Street City Province Postal Code

Home Phone No. _____ ☐ Okay to Call **Message Phone No.** _____

Insurance Type ☐ **MSP** ☐ **WCB** ☐ **Out-of-Province** ☐ **Self-Pay** Other: _____ RCMP or Armed Forces #: _____

Interpreter Required: ☐ **No** ☐ **Yes** **Language:** _____

REASON FOR REFERRAL:

SPECIAL CONSIDERATIONS

☐ Mental Health Issues ☐ Hearing Issues ☐ Visual Issues ☐ In wheelchair ☐ Other

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PAST HISTORY		
Past Medical History	Past Family History	Past Social History

OTHER MEDICAL ISSUES

☐ Heart Disease	☐ Dyslipidemia	☐ Kidney Disease	☐ Eye Disease	☐ G.I. Problems
☐ Hypertension	☐ Depression	☐ Mental Health	☐ Respiratory Disease	☐ Sexual Dysfunction
☐ Stroke	☐ Diabetes Type 1	☐ Diabetes Type 2	☐ Anxiety	☐ Dementia
☐ Other				

MEDICATIONS (or attach medication record)

ALLERGIES

Family Physician (if different from referring source)

Name: _____

MSP #: _____

Phone: _____ Fax: _____

☐ Patient has no GP/NP

Referring Health Care Provider:

Name: _____

MSP #: _____

Phone: _____ Fax:

☐ GP ☐ Specialist ☐ NP ☐ Hospitalist

Referring Physician Signature: _____