fraserhealth

RAPID ACCESS MEDICINE CLINIC REFERRAL INFECTIOUS DISEASES

MSXX101799B Rev: Dec 10/14

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: ☐ **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: Infectious Diseases - Rapid Access Clinic

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

ADDITIONAL CLINICAL INFORMATION:

When to be Seen:

☐ Urgent (within_____ days) ☐ Specific Date _____

Wound: ☐ **Yes** ☐ **No**

Note: FAX any additional/supporting information with this referral form

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