



**RAPID ACCESS MEDICINE CLINIC REFERRAL
INTERNAL MEDICINE**



MSXX105777B

Rev: Dec 10/14

Page: 1 of 1

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

This facsimile is directed in confidence and is intended for use by the individual or entity to which it is specifically addressed. Any other distribution, copy, or disclosure is strictly prohibited. The contents of this facsimile may also be subject to privilege and all rights to that privilege are expressly claimed and not waived. If you have received this facsimile in error, please notify us immediately by telephone. Thank you for your co-operation.