fraserhealth

INTERNAL MEDICINE (IM) CLINIC REFERRAL

Form ID: MSXX105777C Rev: December 20, 2021 Page: 1 of 1

Section A: PATIENT INFORMATION **FAX to Internal Medicine Clinic 604-528-5440**

Patient's Name: _____ **Gender:** _____ **Date of Birth:** _____
(Last) (First) (Middle) (DD/MM/YYYY)

Address: _____ **PHN:** _____
(Street) (City) (Province) (Postal Code)

Primary Tel Number: _____ **Alternate Tel Number:** _____ **Email:** _____

Section B: REFERAAL INFORMATION

PRIORITY: ☐ Routine ☐ Urgent **ALERT(S):** _____ **MOST:** _____

CLINIC: ☐ General IM ☐ Rapid Access ☐ Hypertension ☐ GIM Discharge ☐ Pre Op *(Complete Sections C & D Below)*

Reason for Referral: _____

Medical Reason for Urgency: _____

Relevant Medical History: _____

SECTION C & D REQUIRED FOR ALL PRE OP CLINIC REFERRALS

Section C: SURGICAL PROCEDURE DATE and URGENCY

Type of Surgical Procedure: _____

Scheduled Date of Procedure (date known): _____ ☐ < 7 days

Estimated Date of Procedure (date NOT known) _____ ☐ 7-14 days

Consideration of Fitness for Surgery (no definite date): _____ ☐ Non Urgent

Section D: MEDICAL CONCERNS (Please check all that apply and provide any additional information)

☐ Anticoagulation _____ ☐ Bleeding Disorder _____
☐ Cardiac Risk _____ ☐ Heart Failure _____
☐ Diabetic _____ ☐ Liver Disease _____
☐ Kidney Disease _____ ☐ Pulmonary Disease _____
☐ Medication Management _____ ☐ Other (specify) _____

INCLUDE: ☐ Last 3 months of Bloodwork ☐ Diagnostic Reports ☐ Specialist Consultation ☐ Discharge Summary

☐ Has the patient seen an Internal Medicine Specialist? Name of Dr. _____ Date: _____

Isolation Precautions: ☐ None ☐ Airborne ☐ Contact ☐ Droplet

Interpreter Required: ☐ No ☐ Yes (If Yes, Specify Language): _____

Referring Provider:

Name: _____ **MSP #:** _____ **Date of Referral:** _____

Signature: _____ **Phone:** _____ **Fax:** _____