fraserhealth

Infectious Disease - Rapid Access Clinic - Adult - Referral (ARH)

Send Form to: ☐ **ARH** Fax: **604-851-4766** / Phone: 604-870-7523

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: **MOST** _____ **CCI ALERTS** _____

Referral Date: _____

Priority: ☐ **Routine** ☐ **Urgent**

Interpreter Required: ☐ No ☐ Yes

If yes, specify language _____

Travel Related: ☐ No ☐ Yes

Referring Health Care Provider:

Name: _____

MSP: _____

Site: _____

Phone: _____

Fax: _____

Immunosuppression: ☐ **No** ☐ **Yes, specify:**

Reason for Referral:

Wound: ☐ **No** ☐ **Yes, specify:**

Attach Relevant:

☐ **Consults** _____
☐ **Bloodwork** _____
☐ **Imaging** _____
☐ **Microbiology** _____

Isolation precautions: ☐ **Routine** ☐ **Contact** ☐ **Droplet** ☐ **Airborne**

Name of Primary Care Provider:

Referral Clinic: Infectious Disease - Rapid Access

See Page 2 for address and fax number of clinic.

Fax referral to:

☐ **Abbotsford Regional Hospital - Rapid Access Clinic**
32900 Marshall Road
General Day Care - 3rd Floor
Abbotsford, BC
Phone: 604-870-7523
FAX: 604-851-4766