



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



Form ID: AMXX106854B

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

<b>Patient's Name:</b> _____			<b>Gender:</b> _____		
Last		First		Middle	
<b>Date of Birth:</b> ____/____/____ (DD/MM/YYYY)			<b>PHN:</b> _____		<b>Insurance:</b> _____
<b>Address:</b> _____					
Street		City		Province	
Postal Code					
<b>Contact Method Primary:</b> _____			<b>Alternate:</b> _____		

REFERRAL INFORMATION: MOST \_\_\_\_\_ CCI ALERTS \_\_\_\_\_

<b>Referral Date:</b> _____	<b>Referring Health Care Provider:</b> <b>Name:</b> _____ <b>MSP:</b> _____ <b>Site:</b> _____ <b>Phone:</b> _____ <b>Fax:</b> _____
<b>Priority:</b> <input type="checkbox"/> Routine <input type="checkbox"/> Urgent	
<b>Interpreter Required:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify language _____	
<b>Travel Related:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Immunosuppression:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____	
<b>Reason for Referral:</b> _____ _____	
<b>Wound:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____	
<b>Attach Relevant:</b> <input type="checkbox"/> Consults _____ <input type="checkbox"/> Bloodwork _____ <input type="checkbox"/> Imaging _____ <input type="checkbox"/> Microbiology _____	
<b>Isolation precautions:</b> <input type="checkbox"/> Routine <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne	
<b>Name of Primary Care Provider:</b> _____	
<b>Referral Clinic: Infectious Disease - Rapid Access</b>	

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**Infectious Disease - Rapid Access Clinic -  
Adult - Referral Form**

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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**