

## Generic Referral

Please type directly into the form. Where indicated, required referral information may be attached. Please ensure referral meets specific referral requirements where these are available.

Date (yyyy-Mon-dd)	Refer to	Fax
Referring provider/source		Phone
Address		Fax
Family Physician		
Guardian/Appointed Agent (if applicable)		
Patient Guardian Name	Phone	Relationship
<b>Referral Information</b>		
Reason for referral		
Type of referral <input type="checkbox"/> New referral <input type="checkbox"/> Re-referral <input type="checkbox"/> 2nd opinion <input type="checkbox"/> Urgent referral <input type="checkbox"/> Service/consultant is aware of urgent referral Reason for urgency _____		
Specialist seen previously <input type="checkbox"/> No <input type="checkbox"/> Yes      ▼		
If <b>Yes</b> Date seen	If <b>Yes</b> Diagnosis	Diagnosis Date (yyyy-Mon-dd)
Prior hospital admission (past 2 years) <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, when and where?) _____ <input type="checkbox"/> Currently hospitalized, where? _____		
Past Medical History		<input type="checkbox"/> Attached
Current Medications/Allergies		<input type="checkbox"/> Attached
<b>Requested Action</b>		
<input type="checkbox"/> Confirm and/or advise diagnosis <input type="checkbox"/> Assume future management of patient within area of expertise <input type="checkbox"/> Confirm and/or advise management, including medication <input type="checkbox"/> Telephone consultation <input type="checkbox"/> Assume management for this problem and return patient after care <input type="checkbox"/> Patient education		
<b>Processing Requirements (Check if included)</b>		
<input type="checkbox"/> Blood work <input type="checkbox"/> Diagnostic imaging <input type="checkbox"/> Consultant letters <input type="checkbox"/> Discharge summaries <input type="checkbox"/> Microbiology <input type="checkbox"/> Pathology		
<b>Factors that may affect consultation/care</b>		
Specific patient request <input type="checkbox"/> Physician _____ <input type="checkbox"/> Location _____ Language _____ <input type="checkbox"/> Interpreter required Physical limitations _____ Social/Psychological _____ Economic _____      Other _____		
<b>For office use only</b>		
Name	Signature	Designation
		Date (yyyy-Mon-dd)