Providence HEALTH CARE

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

INTERNAL MEDICINE & RAPID ACCESS REFERRAL

∗All referrals will be triaged and prioritized∗

DATE OF REFERRAL: ____________________

REFERRED FROM:
- ☐ Emergency Department
- ☐ Inpatient unit: ____________________
- ☐ GP or NP: ____________________

PATIENT INFORMATION

Name: ____________________

PHN: ____________________ ☐ Male

DOB: (dd/mmm/yy) ____________________ ☐ Female

Address: ____________________ ☐ Other:

____________________ ____________

City: ____________________ Province: ____________

Postal code: ____________ Email: ____________

Home phone: ____________________

Cell phone: ____________________

Work phone: ____________________

Mobility: ☐ Wheelchair ☐ Other: ____________

☐ Interpreter required Language: ____________

URGENCY:
- ☐ **Rapid Access/Urgent** (within 2 weeks) Reason: ____________________
- ☐ **Non-urgent Internal Medicine Referral**

REFER TO: **Specific site preferred:** ☐ MSJ ☐ SPH ☐ VGH ☐ **Specific specialist:** ____________

REASON FOR REFERRAL: (attach additional relevant information) ____________________

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☐ 'Red flag' symptoms/findings ____________________

Is this a re-referral? ☐ No ☐ Yes ____________________

REFERRING PROVIDER:

Printed name: ____________________ MSP #: ____________

Phone: ____________________ Fax: ____________

FAMILY PHYSICIAN: ☐ Same as above

Printed name: ____________________ MSP #: ____________

Phone: ____________________ Fax: ____________

STAMP

This referral will be triaged by Internal Medicine staff. For prompt booking, ensure all sections are fully completed.∗

FAX COMPLETED REFERRAL TO:

	FAX	PHONE
MSJ	604-877-8375	604-877-8366
SPH	604-806-9057	604-806-8735
VGH	604-875-5906	604-875-5181

∗Please include copies of medication list, lab results, diagnostic imaging reports and any other relevant test results and reports.

ACKNOWLEDGEMENT OF REFERRAL

APPOINTMENT DATE: ____________________ **TIME:** ____________ **LOCATION:** ☐ MSJ ☐ SPH ☐ VGH

WITH DR: ____________________ **CONTACT #:** ____________

- ☐ We will notify your patient of the above appointment
- ☐ Please notify your patient of the above appointment
- ☐ We require the following additional information before we can book an appointment for this patient:

____

- ☐ Recommend referral to (GP to arrange): ____________________

Form No. PHC-OP129(T) (R. Feb 2-17)

These clinics are affiliated with UBC Faculty of Medicine and for this reason clinic patients should expect their visit could include a medical student or resident.