

**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) _____

 '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): _____

