# URGENT MEDICAL ASSESSMENT CLINIC (UMAC) REFERRAL

| PATIENT INFORMATION | SEND RESULTS TO |
|---|---|
| Last Name<br>First Name | Ordering practitioner<br>MSP#<br>Locum |
| Date of birth Year Month Day<br>PHN<br>Primary Contact Number | Clinic Name<br>Street Address<br>Phone<br>Fax Number |
| Patient Address | Primary Care Provider<br>☐ Same as ordering practitioner |
| Special Instructions ☐ Hard of hearing ☐ Interpreter Needed<br>☐ Violence Alert ☐ Other:_____<br>☐ Allergy _____ | Copy to (full name) |

## REFERRAL INFORMATION

**Reason for referral** ☐ Attached

☐Syncope ☐ER follow up ☐Hospital admission follow up ☐Anti-coagulant therapy ☐Pre-operative ☐Chest pain

**Refer to**

☐ First Available Physician ☐ Requested Physician (please specify)_____ ☐ RJH ☐ VGH

**FOR PRE-OPERATIVE PATIENTS ONLY**

**Estimated Surgical Date:** **Procedure:**

## ROUTING

| | | | |
|---|---|---|---|
| UMAC, VGH<br>Phone: 250-727-4212 (x15107)<br>Fax: 250-727-4083 | **Fax: 250-370-8186**<br>**RJH & VGH Referrals Only** | Date of referral<br>Year Month Day | Total # of pages faxed |
| UMAC, RJH<br>Phone: 250-370-8743 (x18743)<br>Fax: 250-519-1871 | | | |

## ACKNOWLEDGEMENT

| | |
|---|---|
| Clinic to acknowledge receipt of referral by faxing this form back to ordering practitioner<br>☐ Received by UMAC | Patients will be contacted directly by UMAC with appointment time. If the wait for the appointment is over 1 month, the ordering practitioner will also be informed |

*If you have questions or would like to suggest changes to this form, please contact RegionalClinicalForms@viha.ca*