

Urgent Medical Assessment Clinic (UMAC) – RJH Intake Form



Instructions:

Fax this form and any other relevant data to the RJH UMAC Clinic.

Date of Referral (DD/MMM/YYYY): _____

Patient First Name: _____

Last Name: _____

Daytime Telephone: _____

MRN (or PHN): _____

Evening Telephone: _____

Birthdate
(DD/MMM/YYYY): _____

Referring Physician: _____

MSP: _____

Royal Jubilee Hospital 250-370-8220

First Available

Dr. Laura Farrell

Dr. Brian McArdle

Dr. Dave Shanks

Dr. Velislava Veleva

Dr. Jeff Kerrie

Dr. Jasdeep Saluja

Jim Spence

Dr. Ali Walzak

Fax: 250-370-8638

Reason for Referral: Urgent Non Urgent

Cardiac history with impact on daily living

Brief history (please describe):

Anti-coagulant therapy

Moderate to severe respiratory disease

Diagnosed or suspected obstructive sleep apnea
w/ other co-morbidities

Poorly controlled diabetes

Morbid obesity (BMI greater than 35) in
conjunction with other identified triggers

Severe liver disease

Severe renal disease

Follow-up from hospital admission

Other: _____

For Surgical Patients Only (in addition to criteria above, indicate reason for referral in advance of surgery):

ASA Classification 3 or 4

Patients requiring anemia management for
procedures that may result in major blood loss

o ASA 3: patient with severe systemic disease

o ASA 4: patient with severe systemic disease that
is a constant threat to life

Estimated Surgical Date: _____

Procedure: _____

Medications (PharmaNet):

UMAC CLINIC ONLY

Triage Code (UMAC Physician Only)

w/ Treadmill

Appointment Date/Time

Resident Appropriate

(MM/DD/YYYY)