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| --- | --- |
| **PATIENT INFORMATION** | **SEND RESULTS TO** |
| Last Name | Ordering practitioner |
| First Name | MSP # Locum |
| Date of birth Year Month Day | Clinic Name Street Address Phone Fax Number |
| PHN |
| Primary Contact Number |
| Patient Address | Primary Care Provider Same as ordering practitioner |
| Special Instructions Hard of hearing Interpreter Needed Allergy \_\_\_\_\_\_\_ Violence Alert Other  | 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 Phone: 250-727-4212(x15107) | **FAX (VGH and RJH)****250-370-8186** | Date of referral Year Month Day | Total # of pages faxed |
| UMAC, RJH Phone: 250-370-8743  |
| ACKNOWLEDGEMENT |
| Clinic to acknowledge receipt of referral by faxing this form back to ordering practitioner 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 |