|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 ONLYEstimated 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 | | | |