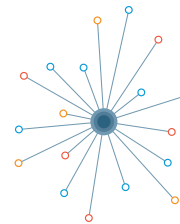


REFERRAL FORM



CENTRAL
REFERRAL SOLUTIONS

GENERAL SURGERY

204 – 300 Columbia St. | Kamloops, BC. | V2C 6L1 250.319.8039 1.250.469.9410

CONSULTATION REQUEST

Patient Name: _____

Address: _____

Home Phone: _____

Workphone: _____

Cell Phone: _____

Email: _____

Birthdate: _____

Sex: _____

PHN: _____

SURGEON REQUEST:

First available
 Specific: _____

PRIORITY: Urgent Elective

If urgent, have you already contacted a surgeon?

No Yes _____
name of surgeon

REASON FOR CONSULTATION:

IS PATIENT ON ANTI-COAGULANTS? No Yes _____

INVESTIGATIONS (include relevant):

_____ Ordered Complete Other
_____ Ordered Complete Other

Referring Physician Name: _____

Phone: _____

Fax: _____

Address: _____

Signature: _____

Date: _____

By signing you agree that you have abided by all legal requirements when collecting, using, and disclosing your client's personal information, including obtaining their consent to disclose the personal information recorded on this form to a third party service provider for the purpose of coordinating the consultation request and arranging the appointment with a specialist.