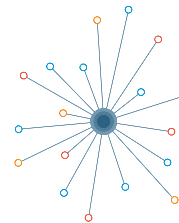
REFERRAL FORM

GENERAL SURGERY



CENTRAL
REFERRAL SOLUTIONS

204 – 300 Columbia St. | Kamloops, BC. | V2C 6L1 p 250.319.8039 f 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:

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IS PATIENT ON ANTI-COAGULANTS? ○ No ○ Yes ______________________

INVESTIGATIONS (include relevant):

______________________ ○ Ordered ○ Complete ○ Other

______________________ ○ Ordered ○ Complete ○ Other

Referring Physician Name: ______________________

Phone: ______________________

Fax: ______________________ **Signature:** ______________________

Address: ______________________ **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.