Internal Medicine Clinic Referral Form

AFFIX PATIENT LABEL

EMERGENCY DEPARTMENT: REFERRAL FOR CONSULTATION TO INTERNAL MEDICINE CLINIC

Referral To: Dr. **Fax #:** ( ) _____

Patient Name: **Tel #:** ( ) _____

Date of Referral: September 9, 2015

CPSO SEARCH

☐ For continued patient follow up

☐ Admission Avoidance

Diagnosis/Reason for Referral:

*(**please indicate if the pt requires isolation - ie: MRSA or other contact precautions)*

Attached: ☐ ED Chart ☐ Labs/Imaging Reports ☐ Other: _____

Urgency: ☐ Urgent: 72 hrs/3 business days ☐ Non-urgent: within 7 days ☐ Non-urgent: 8-14 days

Referring Clinician Name: Dr. _____ ☐ GRH ED ☐ SMGH ED

Signature: _____ **Billing #:** _____

IMPORTANT: PLEASE CONTACT THE PATIENT DIRECTLY (AND NOT THE ED) WITH THEIR APPOINTMENT TIME

Fax to 519-749-4448

☐ *Faxed At:* _____ *By:* _____

PRINT FORM CLEAR FORM