

Internal Medicine Referral

Please fax the completed form to xxx-xxx-xxxx

General internal medicine referrals are accepted from physicians and nurse practitioners.

Priority: ☐ Routine ☐ Urgent (please also phone the clinic)

PATIENT INFORMATION

Last name	First name	Date of birth (YYYY-MM-DD)
Health card number	Version code	Sex
Address (street, city, postal code)	Alternate phone	
Preferred language	Interpreter required? (Yes / No)	Email (optional)

REFERRING PROVIDER

Name	OHIP billing number	CPSO / CNO number
Clinic / practice	Phone	
Address	Fax (for the consultation report)	

REASON FOR REFERRAL / CLINICAL QUESTION

Please describe the clinical question, relevant findings, and what you would like addressed.

ATTACHED WITH THIS REFERRAL

- | | |
|--|--|
| ☐ Past medical history | ☐ Family history |
| ☐ Allergies | ☐ Current medication list |
| ☐ Recent laboratory results | ☐ Imaging / other reports |
| ☐ Relevant clinic notes | ☐ Other (describe below) |

Other / additional information

Referral date (YYYY-MM-DD) Referring provider signature

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Scope Medical · Internal medicine · Kingston, Ontario

This is an outpatient consulting clinic. Patients who are unstable or need same-day assessment should be directed to the emergency department.