



Rapid Access Specialist Clinic
 6184 Fraser Street
 Vancouver, BC V5W 3A1

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REFERRAL FORM

Date:	Patient Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Referring Physician:		DOB:	PHN:
MSP:	Address:		
Clinic Phone:	Clinic Fax:	Home Phone:	Cell:

REFERRAL FOR CONSULTATION	REFERRAL FOR DIAGNOSTICS
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<input type="checkbox"/> General Internal Medicine <input type="checkbox"/> Rheumatology <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Cardiology	<input type="checkbox"/> Holter Monitoring <input type="checkbox"/> with IM consult <input type="checkbox"/> Stress Testing <input type="checkbox"/> with IM consult <input type="checkbox"/> ECG <input type="checkbox"/> Pulmonary Function Testing
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Urgency of Referral:

Urgent [within 2 weeks]
 Semi-urgent [within 2 - 4 weeks]
 Routine

Clinical Questions:

Please include **labs, imaging, other diagnostic reports and relevant medical information** with the referral form. Please note that any incomplete referrals will be returned for completion. A confirmation of referral will be sent to your office. The patient will be contacted for scheduling.

THANK YOU FOR THE REFERRAL