1.2P

REFERRAL FORM

Please note that individuals with the following conditions can **NOT** be referred for treatment:

- *Bleeding disorders*
- *Pregnancy*
- *Anti-coagulated patients*
- *Immunocompromised patients*

REFERRING PHYSICIAN INFORMATION

Attention MOA: Please submit a No-Charge referral **03333** to MSP billing #**63566** (Dr R. Dhanoa) and fax this form to **604-637-5617**

Physician name: MSP number:

Telephone no.: Fax (for consult delivery):

PATIENT INFORMATION

Surname: First name:

Date of birth (DD/MM/YYYY): PHN:

Home phone #: Cell phone #:

Address: Gender:

City/Province: Postal code:

REFERRAL TO: Vancouver Clinic ☐ Outreach (Non-Lower Mainland) ☐

REASON FOR REFERRAL (Enclose history & investigations +/- referral letter)

Language barrier? NO YES (Please advise patient to bring interpreter if language barrier)
Clinical/infection precautions? NO YES :

Physician signature: Date:

912-750 W Broadway, Vancouver BC V5Z 1H8 Tel: 604-537-5635 Fax: 604-637-5617