



REFERRING CLINICIAN INFORMATION

Please submit no-charge referral 03333 to MSP billing no. **63566** (Dr R. Dhanoa) and fax this form to Central Intake (+1-604-637-5617)

Clinician name: MSP/Billing number:
Clinic name & Address: Telephone no.:
Fax no.:
Clinician Signature: Date:

PATIENT INFORMATION

Last name: First name:
Date of birth (DD/MM/YYYY): Gender/pronouns:
PHN: Telephone no.:
Address:

1. SELECT PREFERRED CLINIC LOCATION

Vancouver Delta/Surrey
Victoria Virtual (outreach)

2. SELECT SERVICE REQUIRED

Consultation +/- treatment Pain Education (Virtual)
Fibromyalgia diagnosis and management Virtual consultation only

3. REASON FOR REFERRAL (You **MUST** provide relevant clinical history, PMHx/DHx/Allergies below and enclose investigations and consult reports (as per CPSBC requirements) otherwise the referral will be returned to you and result in a delay for your patient). Referral letter enclosed

4. LANGUAGE BARRIER? NO YES (Please advise patient to bring interpreter)

5. CLINICAL/INFECTION PRECAUTIONS? NO YES (please state):