General Referral Form

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| --- | --- |
| **Instructions** | **Next Steps** |
| 1. Fill out as many fields below as possible
2. Attach relevant documents (e.g., medical history)
3. Submit by:
4. Fax: [X]
5. Secure e-mail: [X]
6. Inform patient that a referral was submitted
 | 1. Patient will be contacted directly to book their appointment
2. Patient will receive follow-up information by e-mail
3. Referring person will receive confirmation of patient appointment within 1-2 weeks
 |

**Referred By**

|  |  |
| --- | --- |
| Name | Organization/Clinic Name |
|  |  |
| Phone | Fax |
|  |  |

**Patient Information**

|  |  |
| --- | --- |
| Legal Name\* | Name Used |
|  |  |
| Personal Health Number | Date of Birth (D/M/Y) | Gender\* | Pronouns |
|  |  |  |  |
| Address (number, street, city, province, postal code) |
|  |
| Phone | Email Address |
|  |  |
| Community Pharmacy (name, location, phone) |
|  |

\* Legal name and gender as stated on your BC Services Card is collected to access health records. We recognize that people’s actual name and gender can differ from what is on their government issued ID.

**Reason(s) for Referral**

|  |
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|  |

**Send a Copy of Consultation Report to…**

|  |  |  |
| --- | --- | --- |
| Name | Phone | Fax |
|  |  |  |