



General Referral Form

Instructions	Next Steps
<ol style="list-style-type: none"> Fill out as many fields below as possible Attach relevant documents (e.g., medical history) Submit by: <ol style="list-style-type: none"> Fax: 1-866-229-3779 Secure e-mail: https://medinetmail.ca/cgi-bin/pharmclinic/pc_signup.cgi?apptype=CU Inform patient that a referral was submitted 	<ol style="list-style-type: none"> Patient will be contacted directly to book their appointment Patient will receive follow-up information by e-mail 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 a person's name and gender can differ from what is on their government issued ID.

Reason(s) for Referral

Send a Copy of Consultation Report to...

Name	Phone	Fax