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REFERRAL REQUEST

Please complete all relevant fields and attach supporting reports.

PATIENT INFORMATION			
Legal name:		Date of birth (YYYY-MM-DD):	
Health card number:		Version code:	
Address:		City / postal code:	
Primary phone:		Alternate phone:	
Preferred language:		Pronouns (optional):	

REFERRING CLINICIAN			
Clinician name:		Billing / licence number:	
Clinic / organization:		Secure email:	
Phone:		Fax:	
Signature:		Date:	

REASON FOR REFERRAL	
Priority: ☐ Routine ☐ Urgent - clinical rationale required below	
Primary clinical question:	
Relevant symptoms, duration, and functional impact:	

CLINICAL INFORMATION	
Relevant medical and surgical history:	
Current medications and allergies:	
Investigations attached: ☐ Laboratory ☐ Imaging ☐ Consultation notes ☐ Other	
Additional information:	

SERVICE-SPECIFIC NOTES	
Common referral areas: Hypertension, Type 2 diabetes, Thyroid disorders, Anxiety and depression, Asthma.	
Submission guidance: A referral is not required for primary-care assessment. Please attach recent medication lists, relevant consultation notes, and available laboratory or imaging results.	