MedRefer.ca

General Medical Referral Form

DEMO FORM

For Demonstration Purposes Only

PATIENT INFORMATION

Full name

Date of birth (YYYY-MM-DD)

Health card / identifier (optional)

Pronouns

Preferred language

Address

Phone

Email

REFERRING PROVIDER

Provider name

Profession / specialty

Clinic / organization

Provider number (optional)

Phone

Fax

Secure email

REFERRAL DETAILS

Priority

- [ ] Routine
- [ ] Semi-urgent
- [ ] Urgent

Requested specialist / service

Reason for referral and clinical question

Relevant history, findings, diagnoses and treatments tried

SUPPORTING INFORMATION

- [ ] Medication list
- [ ] Allergies
- [ ] Consult notes
- [ ] Laboratory results
- [ ] Imaging / reports
- [ ] Other

DEMO LISTING - FOR DEMONSTRATION PURPOSES ONLY

This fictional form must not be used for real patients, clinical referrals, or transmission of personal health information.