Royal Victoria Regional Health Centre

Internal Medicine Clinic Referral

Phone: 705-728-9090 Ext: 23300
Fax: 705-728-3039

Referring Physician: ______________________ Discipline: ____________ Date: ___________

Patient Name: ________________________________ D.O.B (dd/mm/year) ______________

Health Card Number: _________________________ Phone Number: ______________________

Relevant Labs Included? ☐Yes ☐No
Relevant Imaging Studies Included? ☐Yes ☐ No
Previous Consultation Report Included? ☐ Yes ☐ No
***Incomplete referral form will delay appropriate triage and referral time**

Reason for Referral:

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☐ RVH ER Referral ☐ Less than 2 weeks ☐ 4 weeks ☐ ______________

☐RVH Inpatient Discharge ☐ Urgent (1-2 days) ☐ Less than 2 weeks ☐ ______________

☐ DM with Diabetes Educator ☐ Less than 2 weeks ☐ 3 months ☐ ______________

☐ VTE or anticoagulation ☐ Less than 2 weeks ☐ 3 months ☐______________

☐ Perioperative consult Date of surgery: ________________________

☐ Medicine Treatment Clinic Please indicate: ☐ Iron infusion ☐ IVIG ☐ Phlebotomy

☐ Community Referral ☐ 4 weeks ☐ 3 months ☐ 6 months

☐ Benign Hematology Referral ☐ Less than 2 weeks ☐ 4- 6 weeks ☐______________

Please indicate reason for referral:
- ☐ Mild cytopenias (ANC greater than 1.0, Plts greater than 50)
- ☐ Anemia
- ☐ Polycythemia

The following should go directly to **SMRCP Malignant Hematology Clinic:** Multiple myeloma or MGUS, lymphocytosis, thrombocytosis, pancytopenia concerning for bone marrow failure (Hb less than100, ANC less than 1.0, Plts less than 50, or abnormalities on peripheral blood film such as blasts)

Signature Referring Physician: __________________________ Billing Number: ____________

Telephone Number: _______________________ Fax Number: _________________________

RVH-1695 20-June-2018

201 Georgian Drive | Barrie ON | 705.728.9802
www.rvh.on.ca

R.IMCREF

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Internal Medicine Clinic Referral

NAME: ______________________

DOB: ______________________

HRN: ______________________

For Office Use Only:

First Appointment		
Appointment *Date:* *Time:*	*Reminder* ☐ Yes ______________ ☐No	*Arrived:* ☐ Yes ☐ No
Second Appointment		
Appointment *Date:* *Time:*	*Reminder:* ☐ Yes ______________ ☐ No	*Arrived:* ☐ Yes ☐ No
Third Appointment		
Appointment *Date:* *Time:*	*Reminder:* ☐ Yes ______________ ☐ No	*Arrived:* ☐ Yes ☐ No
Reason for 3rd appointment: ☐ *No GP* ☐ *Follow up labs* ☐ *Diagnosis unclear* ☐*IV infusion*		

Target triage time achieved: ☐ Yes ☐ No	*Referral appropriate:* ☐ Yes ☐ No

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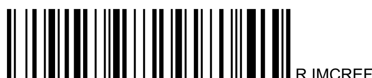

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