Thunder Bay Regional Health Sciences Centre

SURGICAL ASSESSMENT REFERRAL FORM

Place Patient Label with Barcode Here

Guidelines:

1. Physician or Nurse Practitioner to complete referral.
2. **Fax to Surgical Assessment Program at 855-610-2254.** Patient will be contacted by a qualified health care professional to organize the referral booking.
3. Please fax all Urology referrals to **855- 975-2418**
4. A detailed letter can be sent in lieu of this form provided the letter clearly contains all the necessary information requested on the form
5. Completed referral forms will be filed on the patient's health record.
6. Incomplete or illegible referrals will be declined back to the referring provider.
7. Questions - contact the Surgical Central Intake and Assessment Program at **807-684-7103.** For Urology inquiries, please contact Erin Jenner at **807-285-9289**

PATIENT INFORMATION

Last Name, First Name: _____ Date of Birth (day/month/year) _____ Age_____

Sex ☐ Female ☐ Male ☐ Unspecified Health Card Number: _____ Version Code: _____

Address _____ Telephone: Home _____

_____ Postal Code: _____ Work _____ Cell _____

Does the patient have a Family Physician or Nurse Practitioner? ☐ Yes ☐ No WSIB Claim Number _____

Primary Contact (Last Name, First Name): _____

Relationship to Patient: _____ Phone Number: _____

Patient Consent: ☐ Full Consent ☐ Limited Consent

☐ Patient incapable of giving his/her own Informed Consent

☐ Patient to be accompanied by an interpreter at the time of appointment if they do not read/speak English.

REFERRAL INFORMATION

Service: ☐ Cardiovascular ☐ ENT ☐ Dental ☐ General ☐ Gynecology

☐ Plastics ☐ Opthalmology ☐ Thoracic ☐ Urology ☐ Vascular ☐ Neurosurgery ☐ Oral/Maxillofacial

Referral Urgency - ☐ Urgent (provide rationale for urgent request)_____ ☐ Semi-Urgent ☐ Non-Urgent

Preferred Surgeon: YES/NO – if yes, please specify: _____

Preferred Hospitals: YES/NO – if yes, please specify: _____

Reason for Referral/Diagnosis:_____

Please include a referral letter, relevant diagnostic reports, and attach the CPP Health Profile from your EMR. Room for any additional details below

PHYSICIAN/NURSE PRACTITIONER INFORMATION

Date:	
Name:	Signature:
Phone:	Fax:

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