

DATE: _____

PLEASE FAX TO: 778-945-6775

NOTE: All patients require **MEDICAL IMAGING** for triage (see reference sheet for views).

<p>PATIENT INFORMATION (AFFIX LABEL/COMPLETE)*</p> <p>NAME: _____</p> <p>DOB (Y/M/D): _____</p> <p>PHN: _____</p> <p>PHONE: _____</p> <p>EMAIL: _____</p>	<p>REFERRING PHYSICIAN (AFFIX LABEL/COMPLETE)</p> <p>NAME: _____</p> <p>MSP #: _____</p> <p>ADDRESS: _____</p> <p>PHONE: _____</p> <p>FAX: _____</p>
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**Please provide all the requested information. Patients are contacted via email to book their appointment and complete online intake forms. Incomplete referrals will be returned to your office.*

<p>Patient to see FIRST AVAILABLE APPROPRIATE doctor? **</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO: Prefer to see Dr. _____</p> <p>Duration of Symptoms (Circle): 8-12 Wks 3-12 Mos. 12+ Mos</p> <p><i>**All referrals are managed by our Centralized Intake System & triaged by physicians to ensure your patients obtain an appointment with the firsts-available, most-appropriate physician.</i></p>	<p>ACUTE INJURY CLINIC?</p> <p><input type="checkbox"/> YES</p> <p>DATE OF INJURY:</p> <p>_____</p>
<p>WCB CLAIM # _____</p>	<p>ICBC CLAIM # _____</p>

REASON FOR REFERRAL

KNEE HIP

FOOT ANKLE

SHOULDER ELBOW

OTHER: _____

Dx: _____

Rx: _____

Investigations: _____

Previous Medical/Surgical Hx: _____

RIGHT LEFT BOTH Medications: _____

<p>URGENT REFERRALS:</p> <p>Patients requiring assessment within 15 days (ie: suspicion of infection or fracture) should call our office directly: 778-945-6756 xt 112 and follow up on the faxed referral.</p>
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OUR PHYSICIANS

Dr. Michelle Brousson * Dr. Ali Chaudhary * Dr. Teri Fisher * Dr. Sara Forsyth * Dr. Jordan Leith
 Dr. Parth Lodhia * Dr. Murray Penner * Dr. Hooman Sadr * Dr. Keith Stothers * Dr. Andrea Velkovic
 Dr. Mike Wilkinson * Dr. Kevin Wing * Dr. Alastair Younger

