St. Michael's

Inspired Care. Inspiring Science.

REFERRAL for General Internal Medicine Clinic

Date:		Phys Billing #	
Ref MD:			
Address:			
Tel:		Fax:	

Patient		DOB:	
Address			
Tel	(H)	(C)	HC#:
Email:			

Reason for Referral

Type of referral

☐ New ☐ Re-referral ☐ 2nd opinion ☐ Urgent

Reason for Urgency:

Specialist seen previously (past 24 months) ☐ No ☐ Yes **If yes....please list**

Date seen	Specialty	Diagnosis

Past Medical History	Current Medications/Allergies

Factors that may affect consultation/care

☐ Interpreter required (Language ________________________________)

☐ Physical limitations ____

☐ Social/Psychological ____

☐ Economical ____________________________ ☐ Other________________________________

FAX REFERRAL TO 416-864-5714

TRIAGING REMARKS (CLINIC STAFF ONLY)	
Date Received:	
Diagnosis:	
To be booked:	□ **Urgent** □ **next available** □ **non-urgent**
To be declined:	□ **not appropriate for GIM** □ **out of catchment area** □ **seen many specialists** (nothing for us to add) □ **needs another specialist** □ **needs further testing prior to being seen**
Further action required: ☐ Confirm Reason for Referral (RFR) in more detail ☐ Provide □ **Bloodwork** □ **Diagnostic imaging** □ **Consult Letters** □ **Discharge summary** □ **Medication list** □ **Pathology** ☐ Patient's Healthcard Number ☐ Patient's address / telephone (or alternate tel) ☐ Other	
Appointment sent:	
Decline letter sent:	

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