



INTERNAL MEDICINE PREOPERATIVE ASSESSMENT REFERRAL

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Please provide the following information and fax the complete form and relevant reports to +1 (833) 665-7943. Incomplete referral forms will delay assessment.

Patient Information			
Last Name*:		First Name*:	
DOB* (dd/mm/yyyy)	Age*:	(at birth) Gender*:	HCN*:
Address*:		City and Postal code*:	
Main Phone*:		Email*:	
Referring Physician			
Name*:			
Address*:		City and Postal code*:	
Phone*:		Fax*:	
Billing Number*:		Signature*:	
Surgery information			
Reason for surgery:			
Proposed Surgery:			
Date of the surgery:		Expected surgery duration:	
Comments:		Expected length of stay:	
		Day Surgery ☐ or days	
Medical information			
Please attach:			
- Patient profile and medication list. - Recent blood work and relevant consult notes. - Family doctor (or other physician) referral for surgery.			
Primary Care Provider			
Name:			
Address:		City and Postal code:	
Phone:		Fax:	

Date of the referral: ____/____/____

For office use: