

LOWER SURGERY REFERRAL FORM

DIAMOND HEALTH CARE CENTRE,
VANCOUVER GENERAL HOSPITAL

*To be completed by Primary Care Provider. Please complete the fields below as thoroughly as possible.
Fax completed form to: 604-875-5075*

Date of referral (YYYY-MM-DD): _____

CLIENT DETAILS

Last name: _____ First name: _____

Legal name (as appears on CareCard): _____ Pronouns: _____

PHN: _____ Date of birth (YYYY-MM-DD): _____ ☐ Under 18yrs?

Address: _____ City: _____

Province: _____ Postal Code: _____ Email: _____ ☐ consent to email

Primary Phone: _____

Ok to leave message? ☐ Yes ☐ No

Phone Type: ☐ Home ☐ Work ☐ Cell ☐ Other

Alternate Phone: _____

Ok to leave message? ☐ Yes ☐ No

Phone Type: ☐ Home ☐ Work ☐ Cell ☐ Other

Primary Language: _____ Interpreter required? ☐ Yes ☐ No

PROVIDER INFORMATION

Referring Physician Name: _____

Address: _____

Role: _____ Phone: _____ Fax: _____

Primary Care Provider (if different from referring physician): _____

Address: _____

Role: _____ Phone: _____ Fax: _____

REFERRAL DETAILS

1. ELIGIBILITY CRITERIA. Has the patient:

☐ Completed all required surgical readiness assessments (PLEASE ATTACH)

Assessment 1 Date and Assessor Name: (YYYY-MM-DD) _____

2. Past Medical History

3. Medication





Please describe: _____



☐ No ☐ Yes; Please describe: _____

[illegible]

Provider Name: _____ **Signature:** _____ **Date (yyyy-mm-dd):** _____



Please attach completed assessment letters and Fax to:
604-875-5075