

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

