INTERNAL MEDICINE PREOPERATIVE ASSESSMENT REFERRAL

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Please provide the following information and fax the complete form and relevant reports to **519-836-5199**. Incomplete referral forms will delay assessment.

Patient Information			
Last Name:		First Name:	
DOB: (dd/mm/yyyy)	Age:	Gender:	HCN:
Address:		City and Postal code:	
Cell 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: Is the patient staying overnight post op? Y☐ N☐

Medical information
Comorbidities: (check all that apply) HTN☐, DM☐, heart attack / CAD☐, heart failure☐, stroke☐, TIA☐, OSA☐, kidney disease☐, COPD☐, Afib☐, smoking☐, significant alcohol use☐. Others:
Please attach: - **Recent blood work, updated medication list and relevant consult notes.** - **Family doctor (or other physician) referral for surgery.**

Primary Care Provider	
Last Name:	First Name:
Address:	City and Postal code:
Phone:	Fax:

Date of referral:

For office use: