INTERNAL MEDICINE PREOPERATIVE ASSESSMENT REFERRAL

gimclinic.ca
hello@gimclinic.ca
Tel: (226) 270-8618
Fax: 1 (833) 665-7943
PO Box 27030
Guelph RPO Clair, ON, N1L 0C1

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: Mount Albert, N1L0M2
Phone:	Fax:

Date of the referral: _____/_____/_____

For office use: