



ACUTE INTERNAL MEDICINE SERVICE (AIMS) 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: | Sex (at birth): | HCN: |
| Address: | | City and Postal code: | |
| Cell phone: | | Email: | |

| Referring Physician | Primary Care Provider <input type="checkbox"/> same as referring provider |
|---------------------|---|
| Name: | Name: |
| Address: | Address: |
| Phone: | Phone: |
| Fax: | Fax: |
| Billing Number: | Billing Number: |

| Case Priority (if we are unable to see the patient in this timeframe you will be informed so to find an alternate option) | | |
|---|---|---|
| <input type="checkbox"/> High (1 – 2 weeks) | <input type="checkbox"/> Medium (3 – 4 weeks) | <input type="checkbox"/> Low (4 – 12 weeks) |

| Reason for referral | | |
|--|--|--|
| <input type="checkbox"/> new/severe/uncontrolled HTN | <input type="checkbox"/> new desaturation NYD | <input type="checkbox"/> acute kidney injury / new CKD |
| <input type="checkbox"/> new/decompensated CHF | <input type="checkbox"/> new/decompensated COPD | <input type="checkbox"/> electrolyte disturbances |
| <input type="checkbox"/> new chest pain NYD | <input type="checkbox"/> new/uncontrolled diabetes | <input type="checkbox"/> new hepatitis / cirrhosis |
| <input type="checkbox"/> new shortness of breath NYD | <input type="checkbox"/> new hypo/hyperthyroidism | <input type="checkbox"/> new diarrhea/colitis NYD |
| <input type="checkbox"/> new peripheral neuropathy | <input type="checkbox"/> new anemia/thrombocytopenia | <input type="checkbox"/> unintended weight loss NYD |
| <input type="checkbox"/> initial malignancy workup | <input type="checkbox"/> cellulitis / other infections | <input type="checkbox"/> fever of unknown origin |
| <input type="checkbox"/> post-discharge evaluation | | |

| Acknowledgement by referring provider |
|---|
| The GIM Clinic's Acute Internal Medicine Service (AIMS) provides assessment and acute management for patients with new or worsening medical concerns, prioritizing cases that require urgent attention. Patients receive diagnostic evaluation, initial treatment, and stabilization before returning to their Primary Care Providers or any specialists involved. Most patients are seen for three to five visits before discharge. If a patient does not have a Primary Care Provider, follow-up will return to the referring physician. By signing this referral form, I acknowledge and accept these terms. |

Referring Provider Signature: _____ Date: _____

Required attachments:

1. Patient profile (past medical history, surgical history, social history, medications)
2. Latest encounter notes.
3. Pertinent specialist notes.
4. Diagnostic test reports for the past year.