



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 <input type="checkbox"/> N <input type="checkbox"/>	

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

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

Date of the referral: ____ / ____ / ____

For office use: