INTERNAL MEDICINE PREOPERATIVE ASSESSMENT REFERRAL

GIM CLINIC GUELPH INTERNAL MEDICINE

gimclinic.ca
hello@gimclinic.ca
Tel: (226) 270-8618
Fax: (519) 836-5199
PO Box 27030
Guelph RPO Clair, ON, N1L 0C1

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

Name:	
Address:	City and Postal code:
Phone:	Fax:

Date of the referral: ____/____/____

For office use: