William Osler Health System

Peel Memorial Centre for Integrated Health and Wellness
20 Lynch St, Brampton, ON L6W 2Z8
Phone: 905-863-2563
ext. 22563 & 29589
Fax: 905-863-2518

Patient Identification

Peel Memorial Urgent Medical Clinic

REFERRAL FORM

Service Information

Source of Referral (Check location) ☐ UCC ☐ Other ____________ **Referral Criteria Reviewed** ☐ (Check in agreement)

Inclusion Criteria

- ☐ SOB NYD
- ☐ TIA, Syncope
- ☐ Pneumonia, COPD, asthma
- ☐ CHF, palpitations
- ☐ Initial work up for cirrhosis, hepatitis
- ☐ Diarrhea
- ☐ Significant weight loss
- ☐ Acute kidney injury
- ☐ Hypertension, early stage CKD
- ☐ Initial workup for peripheral neuropathy
- ☐ Electrolyte disturbance, edema NYD
- ☐ Anemia, thrombocytopenia
- ☐ Cellulitis
- ☐ Fever in returned traveler or unknown origin
- ☐ Diabetes, hypo/hyperthyroidism
- ☐ Allergic reaction (non anaphylactic)

Exclusion Criteria

- ☐ Seizures
- ☐ Chronic fatigue
- ☐ ICD pacemaker, history of congenital heart disease, valvular heart disease
- ☐ Lung nodules, lung cancer, pleural effusion not tapped
- ☐ HIV patients, joint infections, CNS infection, osteomyelitis
- ☐ All transplant
- ☐ IBD/IBS GI bleed, gallbladder disease, pancreatic lesions
- ☐ Chronic medical illness with no acute change in status
- ☐ Glomerulonephritis, renal cell carcinoma
- ☐ Dementia
- ☐ Dermatology cases
- ☐ ENT patient
- ☐ Pregnancy
- ☐ Pediatric patients < 18 years
- ☐ Undifferentiated back pain
- ☐ Patient on dialysis
- ☐ Patient meeting SIRS criteria

Referral Instructions

1. For referrals from the Peel UCC, Clerk will book patient appointment.
2. Complete form.
3. Attach relevant medications and diagnostic reports.
4. Attach UCC facesheet (if applicable)
5. Fax submission.
6. Send patient with original referral form.

Patient Information

Patient's Last Name: ____________________ **Patient's First Name:** ____________________

Date of Birth: (DD/MM/YY) ____________________ **Gender:** ☐ Male ☐ Female ☐ Other

Health Card Number: ______________ **Version:** __________ **No OHIP:** ☐

Address: ____________________ **City:** ____________ **Province:** ______ **Postal Code:** ______

Phone # (primary): ____________ **Phone # (alternate):** ____________ **Cell #:** ____________

Patient's E-mail: ________________ ☐ **Interpretation Services Required; Language:** ____________

Person to contact for booking appointment *(If different than patient):* ______________________

Relationship to patient: ______________________________

Reason for Referral & Relevant Patient History *(See over for additional space)*

Reason for Referral: ______________________________

URGENCY RATING:
- ☐ < 48 hours (High)
- ☐ 48 - 72 hours (Medium)
- ☐ > 72 hours (Low)

Relevant History: ______________________________

Results of Examination & Investigations: ______________________________

Known Medications: ______________________________

Blood Work
BLOOD WORK REQUIRED: ☐ **YES** ☐ **NO** **- If yes please indicate which blood work on red order sheet and ask patient to come to the clinic 2 hours before their appointment time.**
Referring Clinician Information
Referring Clinician Name: ______________________________ **OHIP Billing Number:** ________________________________
Phone #: ____________________________ **Fax #:** ____________________________ **E-mail:** ____________________________
Family Physician *(If different from above)*: ____

Signature of Referring Clinician: ___________________________ **Referral Date:** ____

Additional Notes/ Comments

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Clinic Use Only (UMC and UCC)

Referral Review: Approved ☐ Re-directed

Reason**:** ____

Date of Review**:** ____

Appointment Information

Appointment Date: ____

- When arriving for your appointment, register in the main lobby of Peel Memorial
- The clinic is located on Level 2 in the Purple area

Form # 8400-057-02/02/2017

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