William Osler Health System SCOPE

Patient Identification

William Osler Health System
ACS-Acute Surgery Clinic
REFERRAL FORM [For Central West Ontario Health Team SCOPE Program]

Referral Information

Inclusion Criteria	Exclusion Criteria
☐ Palpable peri-anal abscess	☐ Lipoma or Cysts
☐ Rectal bleeding [severely painful; with/without anemia; mass]	☐ Non-urgent, non-painful rectal bleeding
☐ Non-facial, large infected sebaceous cysts /abscess	☐ Acute illness that requires emergency department work-up
☐ Obvious fistula with problems	☐ Un-differentiated diagnosis that requires further imaging and/or bloodwork
☐ Symptomatic ultrasound confirmed cholelithiasis (Must not have fever, jaundice or acute pain requiring ER or further work up, and attach imaging confirming cholelithiasis)	☐ Abdominal pain or any pain not diagnosed and not imaged via x-ray or ultrasound
☐ Symptomatic hernia with concerning imaging findings (must have imaging that is concerning as part of referral)	

Referral Instructions

1. Call SCOPE at 905-494-6686 and press 4 to speak to the SCOPE Nurse Navigator.
2. Complete form.
3. Attach relevant medications and diagnostic reports.
4. Fax submission to SCOPE Nurse Navigator for review.

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

Reason for Referral: _____

_____

Relevant History: _____

_____

Results of Examination & Investigations: _____

_____

Known Medications: _____

_____

Additional Notes/Comments

_____

_____

_____

Referring Physician Information

Physician Name: _____ Physician Fax Number: _____

Physician Address: _____

Date of Referral: _____

Physician Signature: _____

Nurse Navigator Use Only

Referral Review: ☐ Approved ☐ Declined

Reason**:** _____

Date of Review**:** _____

Appointment Information

Appointment Date: _____