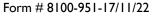




## William Osler Health System

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

Referral Information				
Inclusion Cr	iteria		Exclusion Cr	iteria
☐ Palpable peri-anal abscess		☐ Lipoma	-	
☐ Rectal bleeding [severely pa anemia; mass]		□ Non-urgent, non-painful rectal bleeding		
☐ Non-facial, large infected se	facial, large infected sebaceous cysts /abscess		mergency department	
☐ Obvious fistula with problems			☐ Un-differentiated diagnosis that requires further imaging and/or bloodwork	
Symptomatic ultrasound cor (Must not have fever, jaundi requiring ER or further wor imaging confirming cholelith	ce or acute pain k up, and attach		☐ Abdominal pain or any pain not diagnosed and not imaged via x-ray or ultrasound	
Symptomatic hernia with co findings (must have imaging part of referral)				
<ol> <li>Complete form.</li> <li>Attach relevant medications.</li> </ol>	and diagnostic reports			
<ul><li>3. Attach relevant medications</li><li>4. Fax submission to SCOPE N</li></ul> Patient Information	urse Navigator for revie			
<ul><li>3. Attach relevant medications</li><li>4. Fax submission to SCOPE N</li></ul>	urse Navigator for revie		cient's First Name:	
<ul><li>3. Attach relevant medications</li><li>4. Fax submission to SCOPE N</li></ul> Patient Information	urse Navigator for revie	Pat		
<ul><li>3. Attach relevant medications</li><li>4. Fax submission to SCOPE N</li><li>Patient Information</li><li>Patient's Last Name:</li></ul>	urse Navigator for revie	Pat	_ <b>Gender:</b> □ Male	☐ Female ☐ Other
3. Attach relevant medications 4. Fax submission to SCOPE N  Patient Information  Patient's Last Name:  Date of Birth: (DD/MM/YY)	urse Navigator for revie	Pat Version:	_ <b>Gender:</b> □ Male	☐ Female ☐ Other
3. Attach relevant medications 4. Fax submission to SCOPE N  Patient Information  Patient's Last Name:  Date of Birth: (DD/MM/YY)  Health Card Number:	urse Navigator for revie	Pat Version:	_ <b>Gender:</b> □ Male	☐ Female ☐ Other
3. Attach relevant medications 4. Fax submission to SCOPE N  Patient Information  Patient's Last Name:  Date of Birth: (DD/MM/YY)  Health Card Number:  Address:	urse Navigator for revie Province:	Version:Postal Cod	_ Gender:   Male	□ Female □ Other No OHIP: □
3. Attach relevant medications 4. Fax submission to SCOPE N  Patient Information  Patient's Last Name:  Date of Birth: (DD/MM/YY)  Health Card Number:  Address:  City:	urse Navigator for revie Province:	Pate Version: Postal Code one # (altern	_ Gender:   Male	□ Female □ Other No OHIP: □
3. Attach relevant medications 4. Fax submission to SCOPE N  Patient Information  Patient's Last Name:  Date of Birth: (DD/MM/YY)  Health Card Number:  Address:  City:  Phone # (primary):	urse Navigator for revie Province: Pho Patient's E-mail	Version: Postal Codene # (alternetic)	_ Gender:    Male	□ Female □ Other No OHIP: □
3. Attach relevant medications 4. Fax submission to SCOPE N  Patient Information  Patient's Last Name:  Date of Birth: (DD/MM/YY)  Health Card Number:  Address:  City:  Phone # (primary):  Cell #:	urse Navigator for revie Province: Pho Patient's E-mail equired - Language: _	Version: Postal Codene # (alternet)	Gender:  Male le: ate):	□ Female □ Other  No OHIP: □
3. Attach relevant medications 4. Fax submission to SCOPE N  Patient Information  Patient's Last Name:  Date of Birth: (DD/MM/YY)  Health Card Number:  Address:  City:  Phone # (primary):  Cell #:  Interpretation Services R	urse Navigator for revie Province: Pho Patient's E-mail equired - Language: _	Version: Postal Codene # (alternet)	Gender:  Male le: ate):	□ Female □ Other  No OHIP: □







## **Patient Identification**

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:	Dhysisian Fay Number
Physician Address:	
Date of Referral:	
Physician Signature:	
Nurse Navigator Use Only	
Referral Review:   Approved   Declined	
Reason:	
Date of Review:	
Appointment Information	
Appointment Date:	



