William Osler Health System SCOPE

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

Patient Identification

Referral Information

Inclusion Criteria	Exclusion Criteria
☐ Palpable peri-anal abscess or pilonidal abscess that requires drainage	☐ Lipoma or cysts
☐ Severely painful rectal bleeding with/without anemia and corresponding mass (40+ years old)	☐ Non-urgent, non-painful rectal bleeding
☐ Non-facial, large (over 5cm) infected sebaceous cysts/abscess that likely requires drainage	☐ Acute illness that requires emergency department work-up
☐ Breast abscess or mastitis not improving after course of antibiotics	☐ Un-differentiated diagnosis that requires further imaging and/or bloodwork
☐ Significant, symptomatic gall stones (in and out of emerge) over the last three months	☐ Abdominal pain or any pain not diagnosed and not imaged via x-ray or ultrasound
	☐ Symptomatic hernia
	☐ Obvious fistula with problems
	☐ Ultrasounds confirmed gall stones with no acute symptoms (no fever, jaundice, or acute pain requiring ED or further work up)

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:

____

Form # 8100-951 18/03/2025

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: ______________________ 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: ______________________

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