Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

NEW PATIENT REFERRAL FAX FORM
Fax this Referral to KHSC – General Internal Medicine @ 1-855-247-4613

*For assistance completing, contact **KHSC – General Internal Medicine** @ (613) 533-2056*

PATIENT INFORMATION			
Surname		Mobile	
First name		Home	
Date of Birth (yyyy/mm/dd)		Business + Ext	
Street Address			
City, Province, Postal Code			
Health Card Number, Version Code, Province			
Email			

CLINICAL INDICATION / HISTORY		
Urgency	.	
Please Note: Patients who require same day or very urgent referral should be discussed with the clinician on call 24/7.		
Patient has been seen or followed by a general internist before	.	
	If ***yes,*** provide details and *attach relevant information* as outlined at bottom of form.	
	Name of Physician	
	Previous Reason	
	Date Seen (yyyy/mm/dd)	

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SUB-SPECIALTY – ***CHOOSE BETWEEN 2 STREAMS***			
General Internal Medicine (Consult)		**Obstetric Medicine** (sub-specialty of General Internal Medicine)	
Select *Reason(s) for Referral* to **General Internal Medicine** If applicable, select all that apply from below.		Select *Reason(s) for Referral* to **Obstetric Medicine** If applicable, select all that apply from below.	
☐	Hypertension	☐	Preconception
☐	Anemia	☐	Hypertension (Hypertensive disorder of pregnancy)
☐	Fatigue	☐	Syncope / Presyncope
☐	Weight Loss	☐	Anemia
☐	Night Sweats	☐	Thrombocytopenia
☐	Dyspnea	☐	Thyroid Disorders
☐	Iron Infusions	☐	Headache
☐	Hyponatremia	☐	Venous Thromboembolic Disease
☐	Abnormal Bloodwork (e.g. High ferritin, High ALP, etc.)	☐	GI Symptoms (e.g. nausea, diarrhea, etc.)
☐	Other	☐	Arrythmia
		☐	Iron Infusions
		☐	Other
		Gestational Age (weeks)	
		Patient is being seen by Maternal Fetal Medicine (Dept of OB/GYN)	.
		Patient is being seen by another specialty in this pregnancy	.
		If ***yes***, specify	
Details			
If preferred specialist is being requested, please provide name:			

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ADDITIONAL PATIENT INFORMATION					
Patient is aware of the referral		.			
Patient requires a caregiver / companion		.			
If ***yes***, provide details	Name				
	Relationship to Patient				
	Contact Information				
Patient requires communication regarding this referral to include another contact (*e.g. Power of Attorney, Family Member, Caregiver)*		.			
If ***yes***, provide details	Name				
	Contact Information				
Patient requires a translator	.	If ***Yes***, indicate Language			
Height (cm)		Weight (kg)		Gender	.

CURRENT or PAST DIAGNOSES	
Current Problems	
Past Medical History	

CURRENT MEDICATIONS / TREATMENTS	
Medications	
Treatments	

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ADDITIONAL RELEVANT INFORMATION	
Details	
Please **attach** relevant information, including: • Imaging reports • Lab reports • Pathology reports • PRIVATE clinic consultation notes, investigation reports, mental health consults, etc.	
REFERRING CLINICIAN INFORMATION	
Include the following information in the space provided to the right: (can use a label or stamp) Site Name Phone Fax Address City, Province, Postal Code Billing Number Professional ID Clinician Type	
Signature	
Printed Name, Designation	
Date (yyyy/mm/dd), Time (hhmm)	
Copy of referral and / or status updates to be sent to:	