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

NEW PATIENT REFERRAL FAX FORM
Fax this Referral to KHSC – Urology @ 1-855-247-4615

*For **assistance** completing, contact **KHSC – Urology** @ (613) 549-6666 ext. 4604*

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 urologist 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)	
If preferred specialist is being requested, please provide name:		

REASON FOR REFERRAL		
If applicable, select all that apply		Microscopic hematuria
		Gross hematuria
		Kidney stone(s)
		Sexual function / Genital abnormalities
		Voiding symptoms
		Cancer assessment
		Pediatric urology
		Other
Details		

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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:	
• Cumulative patient profile (CPP) • Imaging reports	• Investigation results • Lab reports

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:	