Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

KGH

NEW PATIENT REFERRAL FAX FORM
Fax this Referral to KHSC – General Surgery @ 1-855-251-6059

For assistance completing, contact ***KHSC – General Surgery*** *@ NewRefGSinquiries@kingstonhsc.ca*

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 surgeon 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 applicable, select all that apply	☐	Generic General Surgery / Endoscopy	
	☐	Colorectal	
	☐	Hepatobiliary / Endoscopic Retrograde Cholangiopancreatography (ERCP)	
	☐	Surgical Oncology	
	☐	Upper Gastrointestinal	
	☐	Pediatric Surgery	
	☐	Other	
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	

REASON FOR REFERRAL	
Details	

CURRENT or PAST DIAGNOSES	
Current Problems	
Past Medical History	

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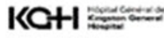

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CURRENT MEDICATIONS / TREATMENTS	
Medications	
Treatments	

ADDITIONAL RELEVANT INFORMATION	
Details	

Please **attach** relevant information, including:

- Cumulative patient profile (CPP)
- Imaging reports
- Lab Reports
- Pathology reports
- Previous Endoscopy and/or OR 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:	