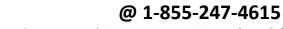


NEW PATIENT REFERRAL FAX FORM Fax this Referral to KHSC - Urology





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

PATIENT INFORMATION								
Surname					Mobile			
First name	9				Home			
Date of Birth (yyyy/mm/dd)					Business	s + Ext		
Street Address								
City, Province, Postal Code								
Health Card Number, Version Code, I				ce				
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 ha	s been	seen or foll	owed by a uro	logist before				
If		If <i>yes,</i> provide details and <i>attach relevant information</i> as outlined at bottom of form.						
		Name of P	hysician					
		Previous R	leason					
		Date Seen (yyyy/mm/dd)						
If preferred specialist is being requested, please provide name:								
REASON F	OR REF	ERRAL						
If applicable, sele			Microscopic hematuria					
			Gross hematuria					
			Kidney stone(s)					
		ct	Sexual function / Genital abnormalities					
all that ap	ply		Voiding symptoms					
			Cancer assessment					
			Pediatric urology					
			Other					
Details								

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



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ADDITIONAL PATIENT INFORMATION								
Patient is aware of the	ne referral							
Patient requires a ca	regiver / c	companion						
	Name							
	Relatio	onship to Patient						
If <i>yes</i> , provide details	Contact Information							
Patient requires com				lude anoth	er			
contact (e.g. Power o		y, Family Member,	, Caregiver)					
	Name							
If <i>yes</i> , provide details	Contact Information							
Patient requires a tra	nslator		If Yes , indi	icate Langu	age			
Height (cm)	V	Veight (kg)	(Gender	·			
CURRENT or PAST DI	AGNOSES	·	<u>.</u>					
Current Problems								
Past Medical History								
CURRENT MEDICATIONS / TREATMENTS								
Medications								
Treatments								



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(A) HOH HARD

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ADDITIONAL RELEVANT INFORMATION							
Details							
Please attach relevant information, including:							
Cumulati	ive patient profile (CPP) • Investigation results						
Imaging	reports • Lab reports						
REFERRING CLINICIAN INFORMATION							
Include the following							
information in the space							
provided to the right:							
(can use a label or stamp)							
a							
Site Name							
Phone							
Fax							
Address							
City, Province, Postal Code							
Billing Number							
Professional ID							
Clinician Type							
Cimelan Type							
Signature							
Printed Name, Designation							
Date (yyyy/mm/dd), Time (hhmm)							
Copy of referral and / or							
status updates to be sent to:							