URGENT MEDICAL ASSESSMENT CLINIC (UMAC) REFERRAL

PATIENT INFORMATION	SEND RESULTS TO
Last Name First Name	Ordering practitioner MSP# Locum
Date of birth Year Month Day PHN Primary Contact Number	Clinic Name Street Address Phone Fax Number
Patient Address	Primary Care Provider ☐ Same as ordering practitioner
Special Instructions ☐ Hard of hearing ☐ Interpreter Needed ☐ Violence Alert ☐ Other:_____ ☐ Allergy _____	Copy to (full name)

REFERRAL INFORMATION

Reason for referral ☐ Attached

☐Syncope ☐ER follow up ☐Hospital admission follow up ☐Anti-coagulant therapy ☐Pre-operative ☐Chest pain

Refer to

☐ First Available Physician ☐ Requested Physician (please specify)_____ ☐ RJH ☐ VGH

FOR PRE-OPERATIVE PATIENTS ONLY

Estimated Surgical Date: **Procedure:**

ROUTING

UMAC, VGH Phone: 250-727-4212 (x15107) Fax: 250-727-4083	**Fax: 250-370-8186** **RJH & VGH Referrals Only**	Date of referral Year Month Day	Total # of pages faxed
UMAC, RJH Phone: 250-370-8743 (x18743) Fax: 250-519-1871			

ACKNOWLEDGEMENT

Clinic to acknowledge receipt of referral by faxing this form back to ordering practitioner ☐ Received by UMAC	Patients will be contacted directly by UMAC with appointment time. If the wait for the appointment is over 1 month, the ordering practitioner will also be informed

If you have questions or would like to suggest changes to this form, please contact RegionalClinicalForms@viha.ca