

COMMUNITY INTERNAL MEDICINE RAPID ACCESS CLINIC REFERRAL (C-IMRAC)

PLACE PATIENT ID
LABEL HERE

 **Initial all boxes and entries**

Phone: 905 522-1155 ext. 39847

Alternate Contact Name: _____

Fax: 905 521-6144

Alternate Contact Phone Number: _____

1. Reason for Referral (please include date of onset of symptoms):

2. Estimated Urgency of Consult Request:

Same Day - Refer Patient to ED 1-3 Days - Call Clinic to Confirm Scheduling will Allow This 3-7 Days

3. Relevant History and Physical Findings:

4. Relevant Medical Background:

5. Attach all Relevant Diagnostics (labs, imaging, consult notes; please include baseline lab values if relevant):

Outstanding Diagnostics Type: _____ Where Performed: _____

6. Is this patient a current CCAC client:

Yes No

7. Does patient require:

Translator Yes No Mobility Assistance Yes No

Does patient have cognitive impairment Yes No

Does patient have a psychiatric diagnosis Yes No

Referral Physician Printed Name: _____ Fax Number: _____

Clinic Name: _____ Phone Number (Backline): _____

Signature: _____ Initials: _____ Discipline: _____

Date of Referral (yyyy/mm/dd): _____

