



Unit #201 – 2460 Commercial Drive  
Vancouver, BC V5N 4B9

(Next to Commercial-Broadway Skytrain Station)

Phone: 778-379-IMSC (4672) / Fax: 778-379-4670

Email: info@infinitymedical.ca

Website: www.infinitymedical.ca

REFERRAL FORM			
Referral Date:	Patient Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	
Referring Physician:	DOB:	PHN:	
MSP:	Signature:	Address:	
Clinic Phone:	Clinic Fax:	Home Phone:	Cell:
Copy reports to:	Contact Person:	Language(s):	

REFERRAL FOR CONSULTATION:	REFERRAL FOR DIAGNOSTICS:
<input type="checkbox"/> <b>Cardiology</b> - Dr. C. Young <input type="checkbox"/> <b>General Internal Medicine</b> - Dr. A. Kang, Dr. Yuanyuan Liu (Ella) <input type="checkbox"/> <b>Hypertension Clinic</b> <i>Please select one: Dr. M. Wong, Dr. A. Kang, Dr. Yuanyuan Liu (Ella)</i> <input type="checkbox"/> <b>Nephrology</b> - Dr. M. Wong <input type="checkbox"/> <b>Physical Medicine and Rehabilitation</b> - Dr. E. Kwong <input type="checkbox"/> <b>Respirology</b> - Dr. J. Chou	<input type="checkbox"/> <b>ECG</b> <input type="checkbox"/> <b>Holter Monitor</b> <input type="checkbox"/> <b>Exercise Stress Test (EST)</b> <input type="checkbox"/> <i>Consult MD if high risk features shown on EST</i> <input type="checkbox"/> <b>Spirometry:</b> <input type="checkbox"/> <i>pre-bronchodilator</i> <input type="checkbox"/> <i>pre- &amp; post-bronchodilator</i> <input type="checkbox"/> <i>Consult MD if ≥ moderate obstruction shown on test</i> <input type="checkbox"/> <b>Home Sleep Apnea Test:</b> *Administered by Medpro Respiratory Care Vancouver Office, an accredited HSAT facility. Please fill out the approved HSAT requisition: <a href="http://www2.gov.bc.ca/assets/gov/health/forms/1944fil.pdf">http://www2.gov.bc.ca/assets/gov/health/forms/1944fil.pdf</a> <input type="checkbox"/> <i>Consult MD if ≥ moderate-severe OSA shown on study</i>

**Urgency of Referral:**     **Urgent** [within 2 weeks] \*     **Semi-urgent** [within 2-4 weeks] \*     **Routine**

\*Every effort will be made to adhere to the above timeline.

**Clinical Question:**

Please fax referral to: **778-379-4670**

Please include **labs, imaging, other diagnostic reports and any relevant medical information** with the referral form. Please note that any incomplete referrals will be returned for completion.

A confirmation of referral will be sent to your office. The patient will be contacted for scheduling.

**THANK YOU FOR THE REFERRAL**