



**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"/> Cardiology - Dr. C. Young <input type="checkbox"/> General Internal Medicine - Dr. A. Kang <input type="checkbox"/> Hypertension Clinic <i>Please select one: Dr. A. Kang</i> <input type="checkbox"/> Nephrology - Dr. M. Wong <input type="checkbox"/> Physical Medicine and Rehabilitation - Dr. E. Kwong <input type="checkbox"/> Respirology - Dr. J. Chou	<input type="checkbox"/> ECG <input type="checkbox"/> Holter Monitor <input type="checkbox"/> Exercise Stress Test (EST) <input type="checkbox"/> <i>Consult MD if high risk features shown on EST</i> <input type="checkbox"/> Spirometry: <input type="checkbox"/> <i>pre-bronchodilator</i> <input type="checkbox"/> <i>pre- & post-bronchodilator</i> <input type="checkbox"/> <i>Consult MD if ≥ moderate obstruction shown on test</i> <input type="checkbox"/> Home Sleep Apnea Test: <i>*Administered by Medpro Respiratory Care Vancouver Office, an accredited HSAT facility.</i> Please fill out the approved HSAT requisition: http://www2.gov.bc.ca/assets/gov/health/forms/1944fil.pdf <input type="checkbox"/> <i>Consult MD if ≥ moderate-severe OSA shown on study</i>
Urgency of Referral: <input type="checkbox"/> Urgent [within 2 weeks]* <input type="checkbox"/> Semi-urgent [within 2-4 weeks]* <input type="checkbox"/> Routine <p style="text-align: center;">*Every effort will be made to adhere to the above timeline.</p>	
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