PROVIDENCE HEMATOLOGY

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Group Referral Form

(Providence Hematology uses a pooling triage system)

Date:

Instructions for referring office (please read): Note: Incomplete referral packages will not be processed
1- All referrals must be completed on this form.
2- Provide as much detail as possible to ensure patient can be triaged quickly and appropriately.
3- Send all investigations and reports from previous years..
4- Our office may ask that patients do additional testing before appointments are given.

PATIENT INFORMATION		
Surname:	Given name:	
DOB:	Gender: ☐ Male	☐ Female
Address:		
Telephone #:		
Health Card Number:		
Interpreter needed:	☐ Yes (language:)	☐ No

PHYSICIAN INFORMATION		
Referring Physician:		
Telephone #:	Fax #:	
Address:		
Was this patient seen by a hematologist in the past: ☐ Yes (Name:) ☐ No		
Other Relevant Physicians Involved:		

REASON FOR REFERRAL:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Relevant investigations to referral (within last 3-5 years). Please check and attach reports:
☐ CBCD ☐ Coagulation ☐ Other blood tests ☐ Biopsies ☐ Imaging

☐ Urgent (within 2-4 weeks) Reason for urgency:
☐ Non-urgent

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