Referral Form

Dr. Sarah Fraser

COASTLINE CLINIC
INTERNAL MEDICINE

PATIENT DETAILS

Name

DOB

PHN

Phone Number

Email

URGENCY

- ☐ Urgent (< 3 wks)
- ☐ Semi-Urgent (<4 mths)
- ☐ Non-Urgent

Final referral priority is determined by Dr. Fraser based on the information provided.

REASON FOR REFERRAL

☐ Consultation ☐ Consultation & Exercise Stress Test ☐ OB-IM consult

PAST MEDICAL / SURGICAL HISTORY

MEDICATIONS

☐ See Attached _____

ALLERGIES TO MEDICATIONS

☐ NKDA ☐ _____

I HAVE INCLUDED:

- ☐ Recent Investigations
- ☐ Relevant Consultations
- ☐ _____

Referring Physician

MSP

Fax

☐ Send me confirmation of receipt

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