St. Joseph's Healthcare Hamilton

❑ Charlton Campus
❑ King Campus
☑ West 5th Campus

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
Fax: 905 521-6144

Alternate Contact Name: _____
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): _____

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Outpatient Inquiry

For C-IMRAC Use Only

Date (yyyy/mm/dd) of Consult: _____ ☐

Time (hh:mm) of Consult: _____ ☐

Referring Physician Name and Billing Number: _____

Contact #/Backline/Cell Number: _____

Consult Information:

_____

_____

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_____

Signature: _____ Printed Name: _____ Discipline: _____ Initials: _____