Brockville General Hospital

General and Internal Medicine & NP CLINICS REFERRAL FORM

PATIENT INFORMATION

Phone: 613-345-5649 Ext. 51300
Fax: 613-345-8308

Referral date (YYYY/MM/DD): _____/____/____ Time (HHMM): _____

Important information for the referring physician:

- The GIM clinic is available Monday to Friday except statutory holidays from 8am to 4pm
- *NEW* Urgent and non-urgent appointments will be booked by the clinic and are not provided in ED
- **All referrals are triaged daily, and appointments will be booked accordingly**

How urgent is your referral?

☐ **Urgent** (24-72 hours)
☐ **Semi-urgent** (1-2 weeks)
☐ **non-urgent**

Provider:

☐ **Dr. S. Bukhari**
☐ **Dr. M Kambale**
☐ **J. Clattenburg, NP**
☐ **Next available**

Reason for consultation (check all that apply):

Internal Medicine
☐ Weight loss NYD
☐ Suspected malignancy NYD
☐ Anemia NYD
☐ Fever NYD
☐ Syncope/pre-syncope
☐ Peripheral edema
☐ Shortness of breath
☐ Chest pain
☐ Palpitations
☐ Atrial fibrillation/flutter
☐ Acute kidney injury

Miscellaneous
☐ Polypharmacy
☐ Falls
☐ New laboratory abnormalities
☐ Diagnostic imaging follow up
☐ Other: _____

Chronic disease management
(unstable disease or no family doctor)
☐ Hypertension
☐ Diabetes
☐ Chronic kidney disease

Ambulatory Care
☐ Cellulitis/wound reassessment
☐ Suture removal
☐ COVID-19 – Remdesivir therapy
☐ Other: _____

Important Notes:

- IV therapy provided during ACU hours Mon-Fri 8am-4pm.
- At this time referrals cannot be accepted for outpatient paracentesis/thoracentesis

Additional Information

Does the patient have a primary care provider? ☐ Yes – Dr. _____ OR ☐ No

Is the patient already undergoing investigation for the issue they are being referred for?
☐ Yes, by their primary care provider – next appointment: _____
☐ Yes, by a specialist provider – Dr. _____ next appointment: _____
☐ No / Not sure

Referral details

_____
_____
_____
_____

IMPORTANT REMINDERS

FAX your consult to the GIM team with a copy of the ED record Fax: 613-345-8308

Please provide the patient with an information handout prior to discharging from the ED

Sign-off

_____	_____	_____	_____/____/____
Physician's Name (print)	Physician's Signature	OHIP Billing Number	Date YYYY/MM/DD

Location: MyBGH/Help My Patient/Patient Care Forms and Resources/Ambulatory Care