Referral Form for Central Intake

FAX to 778 787 1470

Referral DATE:

Referral TO (select one only): First Available Specific Provider:

Patient	**Referring Provider**
Last Name:	MSP#:
First Name:	Last Name:
Middle:	First Name:
PHN:	Office/Clinic Name:
Billing Prov:	Address:
DOB:	City:
Gender:	Province:
Parent/guardian names:	Postal Code:
Contact Info (check preferred):	Phone:
☐ Home:	Fax:
Cell:	
E-mail:	Primary Care Provider (if different than referring provider):
Home Address	
City:	
Province:	
Postal Code:	

Reason for Referral

☐Patient has been seen in person by referring provider

☐Referral letter attached or detail below:

☐Allergies/Medications list attached or detail below:

Please attach if available:

☐ Growth chart

☐ Lab work/Imaging

☐ Allied care reports (eg. audiology, CDC)

☐ Prior consults

If your patient requires urgent care, please call the Pediatrician on call

Consultation reports will be sent back to the Referring Provider

Visit Nanaimopediatrics.ca for useful resources