Print Clear Form

Providence HEALTH CARE

PRE-ADMISSION CLINIC
ANESTHETIC CONSULT REQUEST

* 1 0 4 6 1 *

Referral Other

PRE-ADMISSION CLINIC | Phone: 604-806-8677 Fax: 604-806-8708

Procedure/surgery booked at:

- ☐ Mount Saint Joseph Hospital
- ☐ St. Paul's Hospital

For Office Use Only	Encounter # _____

PATIENT INFORMATION:

Name: _____ PHN: _____
Last First Middle

Date of Birth: (dd/mmm/yyyy) _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Other: _____

Address: _____

Telephone: Home: _____

Cell: _____

Alternate: _____

Primary Care Provider: _____

Referring Physician: _____ Billing #: _____

Approximate Date of Procedure: _____

Procedure Name: _____

Reason for Referral: _____

Attach the following information with your request:

- Most recent lab results
- Relevant patient history
- Any other investigations of relevance (Cardiac / Antenatal / ECT / etc.)

Fax completed request and relevant information to: 604-806-8708

INCOMPLETE FORMS WILL RETURNED TO SENDER