Medical Daycare Booking Form

PATIENT INFORMATION	PROVIDER INFORMATION
First name	Referring practitioner
Last name	MSP # ☐ Locum
Date of birth Year Month Day	Clinic Name Street Address Phone STAMP Fax
PHN	
Primary contact number	
Special Instructions	Primary Care Provider ☐ Same as referring practitioner
MRN (optional)	Copy to (full name)
Email (optional)	Date of referral Year Month Day

DIAGNOSIS/SIGNIFICANT MEDICAL HISTORY

Reason for referral ☐ Attached

Allergies

PHYSICIAN'S ORDERS

Signature

☐ Recurring Encounter Max. 1 year

BOOKING

☐ URGENT (<72 Hours) ☐ Semi-Urgent (within 1 week) ☐ Other: _____

APPOINTMENTS – CLINIC USE ONLY

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ROUTING

Please fax completed form to 250-740-6939
Nanaimo Regional General Hospital, Medical Daycare, 1200 Dufferin Crescent, Nanaimo, BC
Telephone: 250-716-7795

If you have questions or would like to suggest changes to this form, please contact RegionalClinicalForms@islandhealth.ca

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