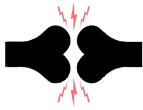

Rheumatology Referral Form

Phone 250 940 4444 Fax 250 385 9600

Rebalance MD

PATIENT INFORMATION: (affix label or complete) Name: PHN: DOB: Gender: Address: Home Phone: Cell Phone: Email:	REFERRING PHYSICIAN: (affix label or complete) Name: MSP: Address: Phone: Fax: Walk in Clinic Name if applicable: FAMILY PHYSICIAN: (if not referring MD)
DATE:	Patient will be seen based on "First Available Appropriate Specialist Triage (FAAST)"

Urgency of Referral: ❐ Urgent ❐ Semi-Urgent ❐ Non-Urgent

Reason for Referral: Letter Attached ❐

Provisional Diagnosis:

Relevant Investigations (eg. Autoimmune serology, imaging):	Prior Immunosuppressive Therapies, Indications, and Duration:
Past Medical History: List Attached ❐	Current Medications: List Attached ❐

Upon review, receipt of referral will be confirmed via fax to referring physician's office. An approximate wait for the appointment will be indicated. Patients will be contacted by our office to schedule appointment. Referring physicians will be advised by fax of appointment date.

Version date: January 2024