Capital Health

Performance Excellence

Referral to the Emergency Department

PLEASE FAX THIS COMPLETED FORM AND PROVIDE A COPY TO PATIENT

- ☐ **Halifax Infirmiry - Phone: 473-4960 Fax: 473-1340**
- ☐ **Dartmouth General - Phone: 465-8338 Fax: 460-4182**
- ☐ **Cobequid - Phone: 865-1160 Fax: 869-3699**
- ☐ **Hants - Phone: 792-2059 Fax: 792-2129**

Patient name Full:

Address:

Postal Code

Date of Birth Gender:

Health card #: Exp.

Date (YYYY/MM/DD): Time:

Specific Reason for Referral:

History of Present Illness:

Past Medical History:

- If this patient may be of high clinical priority, please call the ED.
- If this patient may require another specialist, consider calling consulting service directly or arranging a rapid out-patient referral.
- If the reason for referral is primarily for imaging consider calling diagnostic imaging directly or arranging a rapid out-patient imaging test

Patient/Family Expectation:

Advanced Directive

☐ **Not Discussed** ☐ **DNR** ☐ **Full** ☐ **Other:**_____

Medications: (Or append list)

Lab/Diagnostic Imaging Results:

Relevant Past Medical History: ☐ **Yes** ☐ **No**

Referring Physician **Name (print):**

Mailing Address:

I would like a follow up: ☐ **Yes** ☐ **No**

***Phone # and / or pager number:** ☐

*** ED Physician (or delegate) will call you back if more information is required. Please telephone emergency department/ED Physician if additional information needs to be communicated or to discuss alternate management.**