CONSULTATION FORM

PATIENT INFORMATION

Name:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Birth date (MM/DD/YYYY):	Sex: ☐ M ☐ F
Address:	Health no.:		Home phone no.:	
P.O. box:	City:	Province:	Postal Code:	

CONSULTING PHYSICIAN

Name:	Phone no.:	Prefer a call: ☐ Yes ☐ No Best Time to call:
Address:		Fax no.: E-mail:

P.O. box:	City:	Province:	Postal Code:

Type of Consultation Requested:

☐ One time ☐ Shared Care ☐ Transferred Care

REFERRING PHYSICIAN

Name:	Phone no.:
Address:	Fax no.: E-mail:

P.O. box:	City:	Province:	Postal Code:

CLINICAL INFORMATION

Chief Complaint / Relevant History

Additions to Problem List:

Clinical Findings:

Investigations/Interventions:

Diagnosis: ☐ Confirmed ☐ Provisional ☐ Not yet diagnosed

Treatment and Management Plan (benefits/risks, short/term complications, effects on quality of life, contingency plan in the event of adverse events or failure of first choice treatment):

Current Medications	Unchanged	Changed to	Discont'd
1-	☐		☐
2-	☐		☐
3-	☐		☐

New Medications	**Unchanged**	**Changed to**	**Discont'd**
1-	☐		☐
2-	☐		☐
3-	☐		☐

Prognosis:

Psycho-social concerns (what the patient has been told/aspects likely to influence adherence to the treatment):

Follow-up :

Other physicians consulted :	____ **Signature of Consulting Physician** **Date (MM/DD/YYYY)**

Thank you for this referral.