MIRAMICHI REGIONAL HEALTH AUTHORITY

PROFESSIONAL SERVICES REQUEST

NAME:

CPI:

ADDRESS:

Is this a Workplace Health, Safety & Compensation Commission Case?
(Former WCB)

_____ YES _____ NO

TELEPHONE: (H) _____ (W) _____

DOB: _____ AGE: _____

MEDICARE: _____ ROOM # _____
(INPT)

TO: _____ DATE: _____

FROM: _____ IN-PATIENT ☐ OUT-PATIENT ☐
(UNIT, DEPARTMENT, ETC.)

1) DATE OF ADMISSION _____

2) EXPECTED DATE OF DISCHARGE _____

3) NEXT APPOINTMENT WITH PHYSICIAN _____

LANGUAGE: _____ ***STATUS:*** URGENT ☐ ACUTE ☐ CHRONIC ☐

DIAGNOSIS _____

REASON FOR CONSULTATION: _____

DATE OF ONSET: _____

ADDITIONAL INFORMATION/PRECAUTIONS _____

PLEASE DISCUSS ALL REFERRALS WITH CLIENT ☐ FAMILY ☐ NEXT OF KIN: _____

RELATIONSHIP: _____ TELEPHONE: _____

SIGNATURE-REFERRING PERSON

FILLED BY

PRINT PHYSICIAN'S NAME

•PHYSICIAN SIGNATURE REQUIRED FOR PT/OT (SLP FOR SWALLOWING AND VOICE EENT)

COMPLETE ALL OF THE FORM AND MARK DESTINATION ON REVERSE (FOLD BEFORE SENDING)

FOR DEPARTMENTAL USE ONLY

RECEIVED (DATE/TIME): _____ COMMENTS: _____