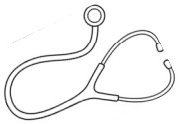
Rebalance MD

Pre-Operative Referral Form

First Available General Internal Medicine

Phone 250 940 4444 Fax 250 385 9600



Date:	
PATIENT INFORMATION: (affix label or complete) Name: PHN: DOB: Address: Cell Phone: Home Phone: Email: Secondary Contact:	**REFERRING SURGEON:** (affix label or complete) Name: MSP: Address: Phone: Fax: **FAMILY PHYSICIAN:**
Urgency of Pre-Operative Consult: ❒ < 1 week ❒ < 2 weeks ❒ < 1 month ❒ Non-Urgent	
Type of Surgery:	
Estimated Length of Surgery in Hours:	
Type of Anesthesia: ❒ None ❒ Local ❒ Neuro-Axial/Spinal ❒ General	
Surgical Date (if known):	
Estimated Length of Stay Post-Operatively (# of Nights): ❒ Day Surgery ❒ 1 ❒ 2 ❒ 3 ❒ Other _____	
MEDICAL CO-MORBIDITIES: Letter Attached ❒	

Patients will be contacted directly by Rebalance[MD] to schedule appointment

Referring physicians will be advised by fax once this referral has been received, and, again, when an appointment has been offered to the patient

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Dr Allan Kostyniuk, MD FRCP(C)
Dr Danny Myers, MD FRCP(C)
Dr Vanja Petrovic, MD FRCP(C)
Dr David Shanks, MD FRCP(C)
Dr Doug Skinnider, MD FRCP(C)
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