North Bay General Surgery Group
General Surgery Referral
Complete and Fax 705-476-6543

Patient Information		
Last Name:	First Name:	DOB:
Health Card #:		Gender:
Address:	City:	Postal Code:
	Phone # (preferred):	
	Phone # (Alternative):	

Physician Information	
Referring Physician:	Phone #:
Billing #:	Fax#:
Referral Date:	Family Physician:
Referring Physician Signature:	

Referral To:
❒ First available Surgeon OR
❒ Patient preferred Surgeon _____*Understand that this may incur a longer wait time*

Reason for Referral: ***Check most urgent reason and include relevant documentation, diagnostic labs or imaging, consults, interventions and referral letter.***			
This referral is:	❒ **URGENT** *(< 2 weeks)*	❒ Semi-Urgent *(2-6 weeks)*	❒ Routine
Cancer *(Suspected or confirmed)*	❒ Breast *(appropriate mammogram, ultrasound and biopsies need to be ordered at time of referral from referring physician)*	❒ GI *(send imaging and relevant documentation if available)*	
	❒ Lymphatic	❒ Skin	
Breast	❒ Benign breast lump/cyst/discharge *(please order and include bilateral mammogram and/or ultrasound)*		
Gastrointestinal	❒ GI bleed/Anemia	❒ Abdominal pain NYD	
	❒ Weight loss NYD	❒ GERD Symptoms	
	❒ Change in bowel habits	❒ Dysphagia	
	❒ Other _____		
Hernia *(ultrasound confirmation not necessary)*	❒ Type _____		
Gallbladder *(include ultrasound if available)*	❒ Biliary Colic	❒ History of Cholecystitis	
Anal/Rectal	❒ Hemorrhoids	❒ Rectal Bleeding	
	❒ Anal fissure	❒ Other _____	
Pilonidal	❒		
Dialysis Access	❒ AV fistula	❒ Peritoneal Dialysis	
Port-a-cath insertion	❒ Include dates of chemo if applicable _____		
ACU procedures	❒ Ingrown toenail	❒ Skin lesion	❒ Other_____
Other	❒ _____		
Relevant Medical History and Pertinent Information			

Complete Medical History and Medication List
list or attach cumulative patient profile