Lions Gate Hospital
part of the Vancouver Coastal Health Authority

OUTPATIENT REFERRAL

Physiotherapy ☐ Occupational Therapy ☐ Arthritis Program ☐

Pre-op Hip/Knee Program ☐ UVL Treatment ☐ Lymphopress ☐

Name of Patient: ______________________________ Sex: M ( ) F ( )
(Last name) (First name)

DOB: ______________________________

Telephone No: ______________ Cell No: ______________

Address ______________________________

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PHN No: ______________

WCB Claim – If yes, please complete this section:

WCB Claim Number: ______________ Occupation: ______________

Time of injury: ______________ Date of injury: ______________

Employer's Name: ______________________________

Telephone Number: ______________________________

Address: ______________________________

Referring Physician: ______________ Family Physician: ______________

Diagnosis: ______________________________

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Surgery Date: (if applicable) ______________________________

Reason for Referral/H_x: ______________________________

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Date of Referral: ______________ Physician's Signature: ______________

For Clerical Use Only				
Rec'd By:	**Date:**	**Dates Patient Telephoned**		
Tent. Appt:			Message left / No answer	
Time Required:			Message left / No answer	
Appt. Date:			Message left / No answer	
Appt Time:		Pre-admitted	☐ Yes	☐ No
Therapist Name:		Old chart ordered	☐ Yes	☐ N/A
		Cancellation Policy	☐ Yes	☐ No

Please forward this referral to the Rehabilitation Service Department
Fax number: 604 984-5744