Religious Hospitallers
of Saint Joseph
of the Hotel Dieu of Kingston
HOTEL DIEU HOSPITAL

PERIOPERATIVE SERVICES GENERAL INTERNAL MEDICINE (GIM) CONSULT: REFERRAL FORM

Etherington Hall, room 1018
94 Stuart Street
Queens University
Kingston, ON K7L 3N6
Telephone: 613 533-2056
Fax: 613 533-6654

_____	_____	_____	_____	_____
Date:(yyyy/mm/dd)	Time:(hhmm)	Referring physician Name:	Designation:	Signature:

Reason for referral: surgery type _____ Surgeon:_____

☐Vascular ☐Orthopaedic ☐General and Thoracic ☐Prostate/Urologic ☐Neurosurgery ☐Bariatric

Reason for referral: risk factor (s):

Cardiac:
☐Chest pain or shortness of breath
☐Arrythmia or palpitations with symptoms
☐Abnormal electrocardiogram (ECG) that seems concerning
☐Uncontrolled hypertension
☐Uncontrolled congestive heart failure
☐Significant valvular disease
☐Multiple cardiac risk factors

Respiratory:
☐Uncontrolled chronic obstructive pulmonary disease
☐Other unstable respiratory conditions

Gastroenterology:
☐Abnormal liver enzymes
☐Cirrhosis

Hematology:
☐History of venous thromboemolism
☐Bridging/anti-platelet therapy

Endocrine:
☐Uncontrolled diabetes
☐Patient on steroids

☐Request for post-operative GIM follow-up

Other:
☐_____

Planned surgery date: (yyyy/mm/dd) _____Other consults/tests requested: _____
_____

Comments:

GIM office use only:

Priority: ☐next clinic ☐1-2 weeks ☐more than 2 weeks
Additional testing prior to visit:_____
_____
Reviewing MD: _____
Date: (yyyy/mm/dd): _____

Scheduled clinic date: (yyyy/mm/dd) _____
Confirmed with patient by: _____
Confirmed with patient on: (yyyy/mm/dd) _____

Scan to referral general internal medicine