COLLABORATIVE CARE
entegrity

WaitLESS Otolaryngology Referral Form

Phone **(250) 212-9003** Fax **(855) 457-4327** Email: **info@entegrity.ca** Website: **ent**egrity.ca

Referral DATE: ______________________

Patients will be contacted by EMAIL or TEXT to confirm appointments:

PATIENT/GUARDIAN EMAIL: (REQUIRED) ____________________________ No Email

PATIENT/GUARDIAN CELL PHONE: (REQUIRED) ____________________________ No Cell Phone

PATIENT INFORMATION:

Name:
PHN:
DOB:
Address:
Daytime Phone:
Evening Phone:
Guardian/Contact Name:

REFERRING PROVIDER:

Name:
MSP:
Phone/Fax:
Clinic Address:

ER/Hospital: ____________

STEP 1: REFERRAL TO

Next available MD (except Dr. _________________) **Specific doctor:** ________________________

Patients being offered the Next Available option will receive the next available appointment with a specialist able to treat the referring condition.

STEP 2: URGENCY

Click to view urgency guidelines and urgency examples

Level 4	Level 3	Level 2	Level 1 *(Send to ED or call for urgent appointment)*

An appointment has already been established for this patient on: ____

STEP 3: PRIMARY PRESENTING PROBLEM (SELECT ONE)

Nasal/Sinus	Otologic	Skin & Oral	Laryngological
Vestibular	Head/Neck	Tonsils/Adenoids/OSA	Other

Symptom Onset Date: _______________ History of/Cancer Suspected

Suspected Diagnosis: ______________________________________

Primary concern:

PENDING INVESTIGATIONS:

PLEASE ATTACH THE FOLLOWING:

- Relevant medical/surgical history, OR reports, consultations, ER reports
- Relevant Investigation results: Diagnostic imaging, laboratory, audiology, sleep studies