Neil J. Wells INC. MD, FRCSC

Plastic & Reconstructive Surgery
Hand & Microvascular Surgery
Cosmetic Surgery

REFERRAL

PLEASE COMPLETE THIS FORM LEGIBLY AND FAX TO OUR CLINIC WITH SUPPORTING DOCUMENTS *

Patient's Name: _____ Birth Date: (dd/mm/yy) _____

Address: _____ PHN: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Other No: _____

Family Doctor: _____

REFERRAL URGENCY: ☐ Emergency ☐ Urgent ☐ Elective ☐ ICBC ☐ WSBC

CLINICAL DIAGNOSIS:

_____

_____

_____

_____

Date: _____ Referring Physician: _____

Billing Number: _____ Signature: _____

Office No: _____ Office Fax: _____

Referring Hospital: _____ Office Contact: _____

X-RAYS: ☐ VGH ☐ PHC ☐ Films sent with patient

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