

**Lakeridge
Health**

Acute Medicine Clinic (AMC)

Telephone: 905-576-8711 x32664 Fax: 905-721-4877

Hours of operation: Monday to Friday 0800 to 1600

**** Patients will NOT be provided with ongoing longitudinal care at the clinic ****

CLINIC EXCLUSIONS:

- Immobility (cannot be the reason for referral)
- Suffers from severe dementia and no caregiver/escort
- Suspicion of influenza
- Not stable clinically for 72 hours
- Procedures required (e.g. paracentesis, thoracentesis)
- Patient of DRCC (issue related to cancer)
- Rashes (or primary dermatological complaint unless obvious systemic issue)
- If patient followed by specialist for their primary complaint (eg Neurologist for seizures or Respiriologist for SOB)

APPOINTMENT DATE: _____ TIME: _____

Instructions for Acute Medicine Clinic provided to patient

REASON FOR REFERRAL:

Priority < 72 hours Within 1 week

Has referral been discussed and patient agreed to AMC services? YES NO

Would this patient have been referred for admission if not referred to this clinic? YES NO

Referring Physician (Print Name)

Referring Physician Billing No.

Referring Physician (Signature)

Date

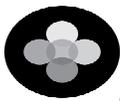
**** ED – Fax this referral form, ED face sheet and ECGs to: 905-721-4877**

**** Inpatient Units – Fax order/referral and call AMC for appointment time prior to patient leaving**

***** Ensure stat discharge dictation is completed *****

White copy to patient; yellow copy to LH chart





**Lakeridge
Health**

Acute Medicine Clinic (AMC)

Telephone: 905-576-8711 x32664 Fax: 905-721-4877

Hours of operation: Monday to Friday 0800 to 1600

**** Patients will NOT be provided with ongoing longitudinal care at the clinic ****

CLINIC EXCLUSIONS:

- Immobility (cannot be the reason for referral)
- Suffers from severe dementia and no caregiver/escort
- Suspicion of influenza
- Not stable clinically for 72 hours
- Procedures required (e.g. paracentesis, thoracentesis)
- Patient of DRCC (issue related to cancer)
- Rashes (or primary dermatological complaint unless obvious systemic issue)
- If patient followed by specialist for their primary complaint (eg Neurologist for seizures or Respiriologist for SOB)

APPOINTMENT DATE: _____ TIME: _____

Instructions for Acute Medicine Clinic provided to patient

REASON FOR REFERRAL:

Priority < 72 hours Within 1 week

Has referral been discussed and patient agreed to AMC services? YES NO

Would this patient have been referred for admission if not referred to this clinic? YES NO

Referring Physician (Print Name)

Referring Physician Billing No.

Referring Physician (Signature)

Date

**** ED – Fax this referral form, ED face sheet and ECGs to: 905-721-4877**

**** Inpatient Units – Fax order/referral and call AMC for appointment time prior to patient leaving**

***** Ensure stat discharge dictation is completed *****

White copy to patient; yellow copy to LH chart

