



**ST. PAUL'S HOSPITAL  
VASCULAR MEDICINE CLINIC  
REFERRAL**



Internal Medicine Referral

Place Patient Form Label Here

Patient name: \_\_\_\_\_  
 PHN: \_\_\_\_\_  Male  Female  
 DOB: \_\_\_\_\_  Other: \_\_\_\_\_  
 (dd/mmm/yyyy)

*This clinic provides comprehensive Internal Medicine care for patients with or at risk for vascular disease. We focus on evaluation and management of sub-optimally controlled vascular risk factors, incidental atherosclerosis found on imaging, demand ischemia/ type 2 MI in multi-morbid patients and myocardial injury after non-cardiac surgery (MINS).*

DATE OF REFERRAL: \_\_\_\_\_

**\*All referrals will be triaged and prioritized**

Patient address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_  
 Postal code: \_\_\_\_\_ Email: \_\_\_\_\_  
 Home phone: \_\_\_\_\_  
 Cell phone: \_\_\_\_\_  
 Work phone: \_\_\_\_\_  
 Mobility:  Wheelchair  Other: \_\_\_\_\_  
 Interpreter required Language: \_\_\_\_\_

**URGENCY:**  Urgent (within 2 weeks) Reason: \_\_\_\_\_  
 Non-urgent

**REASON FOR REFERRAL:** \_\_\_\_\_

**Check all that apply:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Dyslipidemia           | <input type="checkbox"/> Metabolic Syndrome                | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Obesity                           | <input type="checkbox"/> Stroke / TIA                |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Family history of atherosclerosis | <input type="checkbox"/> Coronary Artery Disease     |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Surgery within 1 month            | <input type="checkbox"/> Myocardial Infarction       |
| <input type="checkbox"/> Smoking                | <input type="checkbox"/> Arterial calcification on imaging | <input type="checkbox"/> Demand Ischemia             |

**Was patient admitted to Internal Medicine / CTU recently?**  No  Yes - Physician: \_\_\_\_\_

**REFERRING PROVIDER:**

Printed name: \_\_\_\_\_ MSP #: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**FAMILY PHYSICIAN:**  Same as above

Printed name: \_\_\_\_\_ MSP #: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**STAMP**

**\* For prompt booking, ensure all sections are fully completed.  
 Please include medication list, consult notes, and relevant investigations.**

**FAX COMPLETED REFERRAL TO: 604-602-8661**  
 Location: St. Paul's Hospital, Vascular Medicine Clinic  
 Rm 5900, 5th floor Burrard Building, 1081 Burrard Street, Vancouver, BC, V6Z 1Y6  
 Phone: 604-806-8735 Extension 2