Interlake–Eastern
Regional Health Authority

CONSULT/REFERRAL FORM

Patient Home Address: _____

_____

Patient Telephone: _____

Contact (if different from Patient) _____

TO:

☐ Dr. _____	☐ Physiotherapy	☐ Spiritual Care
☐ Palliative Care	☐ Mental Health Liaison Nurse	☐ Occupational Therapy
☐ Pharmacy	☐ Other _____	
☐ Indigenous Health Intake F# 1-204-785-7045		

FROM: Name/contact

Site:

☐ Selkirk RHC	120 Easton Drive; Selkirk, MB; R1A 2M2	☐ Stonewall	589 3rd Ave; Stonewall, MB; R0C 2Z0
☐ Teulon	162 3rd Ave SE; Teulon, MB; R0C 3B0	☐ Gimli	120 6th Ave; Gimli, MB; R0C 1B0
☐ Ashern	1 Steenson Drive; Ashern, MB; R0C 0E0	☐ Eriksdale	40 Railway Ave; Eriksdale, MB; R0C 0W0
☐ Arborg	234 Gislason Drive; Arborg, MB, R0C 0A0	☐ Beausejour	151 1st Street, Beausejour, MB; R0E 0C0
☐ Pinawa	30 Vanier Ave; Pinawa, MB; R0E 1L0	☐ Pine Falls	37 Maple Street; Pine Falls; R0E 1M0

Reason for Referral / Diagnosis / Med Hx:

Date/Time Requested: _____ **Physician:** _____

Signature (legible): _____

Assessment:

Date/Time: _____ **Signature(legible):** _____