

Height \_\_\_\_\_ cm      Weight \_\_\_\_\_ kg

Allergies \_\_\_\_\_

<b>SCS GIMRAC (GIM Rapid Assessment Clinic) Referral (ED) Order Set</b>		M	K	O												
Orders Processed Date (dd/mm/yyyy)	<b>Please consider if patient is best served by the family physician or a pre-existing sub-specialist before completing referral</b> <input checked="" type="checkbox"/> Please draw labs with corresponding diagnosis if not done in ED, patient should not wait for results <input checked="" type="checkbox"/> Diagnoses not listed below must be reviewed with Internist on-call prior to referral															
Time (hhmm)	<b>Lab Investigations</b>															
By	<input type="checkbox"/> Hypertension: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Urine ACR</td> <td><input type="checkbox"/> Calcium</td> <td><input type="checkbox"/> Magnesium</td> <td><input type="checkbox"/> Phosphorus</td> </tr> <tr> <td><input type="checkbox"/> Albumin</td> <td><input type="checkbox"/> Troponin</td> <td><input type="checkbox"/> TSH</td> <td><input type="checkbox"/> Total Cholesterol</td> </tr> <tr> <td><input type="checkbox"/> Calculated LDL</td> <td><input type="checkbox"/> HDL</td> <td colspan="2"><input type="checkbox"/> Triglycerides (not fasting)</td> </tr> </table>				<input type="checkbox"/> Urine ACR	<input type="checkbox"/> Calcium	<input type="checkbox"/> Magnesium	<input type="checkbox"/> Phosphorus	<input type="checkbox"/> Albumin	<input type="checkbox"/> Troponin	<input type="checkbox"/> TSH	<input type="checkbox"/> Total Cholesterol	<input type="checkbox"/> Calculated LDL	<input type="checkbox"/> HDL	<input type="checkbox"/> Triglycerides (not fasting)	
<input type="checkbox"/> Urine ACR	<input type="checkbox"/> Calcium	<input type="checkbox"/> Magnesium	<input type="checkbox"/> Phosphorus													
<input type="checkbox"/> Albumin	<input type="checkbox"/> Troponin	<input type="checkbox"/> TSH	<input type="checkbox"/> Total Cholesterol													
<input type="checkbox"/> Calculated LDL	<input type="checkbox"/> HDL	<input type="checkbox"/> Triglycerides (not fasting)														
Status	<input type="checkbox"/> Type 2 Diabetes (new onset): <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> HbA1c</td> <td><input type="checkbox"/> Urine ACR</td> <td><input type="checkbox"/> TSH</td> <td><input type="checkbox"/> Total Cholesterol</td> </tr> <tr> <td><input type="checkbox"/> Calculated LDL</td> <td><input type="checkbox"/> HDL</td> <td colspan="2"><input type="checkbox"/> Triglycerides (not fasting)</td> </tr> </table>				<input type="checkbox"/> HbA1c	<input type="checkbox"/> Urine ACR	<input type="checkbox"/> TSH	<input type="checkbox"/> Total Cholesterol	<input type="checkbox"/> Calculated LDL	<input type="checkbox"/> HDL	<input type="checkbox"/> Triglycerides (not fasting)					
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<input type="checkbox"/> Calculated LDL	<input type="checkbox"/> HDL	<input type="checkbox"/> Triglycerides (not fasting)														
Processing Reviewed by	<input type="checkbox"/> Syncope/Heart Failure/Chest Pain/Palpitations: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> BNP</td> <td><input type="checkbox"/> Troponin</td> </tr> </table>				<input type="checkbox"/> BNP	<input type="checkbox"/> Troponin										
<input type="checkbox"/> BNP	<input type="checkbox"/> Troponin															
Status	<input type="checkbox"/> Cellulitis: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Blood Culture Set</td> </tr> </table>				<input type="checkbox"/> Blood Culture Set											
<input type="checkbox"/> Blood Culture Set																
Faxed by	<input type="checkbox"/> Sodium Electrolyte Abnormality: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Urine Osmolality</td> <td><input type="checkbox"/> Serum Osmolality</td> <td><input type="checkbox"/> TSH</td> </tr> <tr> <td><input type="checkbox"/> Urine Sodium</td> <td><input type="checkbox"/> Urine Potassium</td> <td><input type="checkbox"/> Urine Chloride</td> </tr> <tr> <td><input type="checkbox"/> Magnesium</td> <td><input type="checkbox"/> Phosphorus</td> <td></td> </tr> </table>				<input type="checkbox"/> Urine Osmolality	<input type="checkbox"/> Serum Osmolality	<input type="checkbox"/> TSH	<input type="checkbox"/> Urine Sodium	<input type="checkbox"/> Urine Potassium	<input type="checkbox"/> Urine Chloride	<input type="checkbox"/> Magnesium	<input type="checkbox"/> Phosphorus				
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<input type="checkbox"/> Magnesium	<input type="checkbox"/> Phosphorus															
	<input type="checkbox"/> Calcium Electrolyte Abnormality: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Ionized calcium</td> <td><input type="checkbox"/> PTH</td> <td><input type="checkbox"/> Albumin</td> <td><input type="checkbox"/> Magnesium</td> <td><input type="checkbox"/> Phosphorus</td> </tr> </table>				<input type="checkbox"/> Ionized calcium	<input type="checkbox"/> PTH	<input type="checkbox"/> Albumin	<input type="checkbox"/> Magnesium	<input type="checkbox"/> Phosphorus							
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	<input type="checkbox"/> Hepatic Abnormalities (cirrhosis complications, abnormal enzymes, etc.): <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Hep B screen</td> <td><input type="checkbox"/> Hep C Serology</td> </tr> <tr> <td><input type="checkbox"/> Ferritin</td> <td><input type="checkbox"/> INR</td> <td><input type="checkbox"/> Albumin</td> </tr> </table>				<input type="checkbox"/> Hep B screen	<input type="checkbox"/> Hep C Serology	<input type="checkbox"/> Ferritin	<input type="checkbox"/> INR	<input type="checkbox"/> Albumin							
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<input type="checkbox"/> Ferritin	<input type="checkbox"/> INR	<input type="checkbox"/> Albumin														
	<input type="checkbox"/> Hematologic Abnormalities: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Reticulocyte Count</td> <td><input type="checkbox"/> B12</td> <td><input type="checkbox"/> TSH</td> </tr> <tr> <td><input type="checkbox"/> Ferritin</td> <td><input type="checkbox"/> Iron</td> <td><input type="checkbox"/> TIBC</td> <td><input type="checkbox"/> Transferrin Saturation</td> </tr> <tr> <td><input type="checkbox"/> Haptoglobin</td> <td><input type="checkbox"/> Bilirubin</td> <td colspan="2"><input type="checkbox"/> Lactate Dehydrogenase</td> </tr> </table>				<input type="checkbox"/> Reticulocyte Count	<input type="checkbox"/> B12	<input type="checkbox"/> TSH	<input type="checkbox"/> Ferritin	<input type="checkbox"/> Iron	<input type="checkbox"/> TIBC	<input type="checkbox"/> Transferrin Saturation	<input type="checkbox"/> Haptoglobin	<input type="checkbox"/> Bilirubin	<input type="checkbox"/> Lactate Dehydrogenase		
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<input type="checkbox"/> Haptoglobin	<input type="checkbox"/> Bilirubin	<input type="checkbox"/> Lactate Dehydrogenase														
	<input type="checkbox"/> Autoimmune/Inflammatory Arthritis: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Rheumatoid Factor</td> <td><input type="checkbox"/> Anti-CCP</td> <td><input type="checkbox"/> CRP</td> <td><input type="checkbox"/> ANA</td> </tr> </table>				<input type="checkbox"/> Rheumatoid Factor	<input type="checkbox"/> Anti-CCP	<input type="checkbox"/> CRP	<input type="checkbox"/> ANA								
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	<input type="checkbox"/> Other: _____ <input type="checkbox"/> Lab Tests: _____															

Telephone Order \_\_\_\_\_  
 Ordering Practitioner, Designation      Signature      Date/Time (dd/mm/yyyy hhmm)

If Telephone Order \_\_\_\_\_       Read Back  
 Ordering Physician      Date (dd/mm/yyyy)      Time (hhmm)



**Chart Copy – Do Not Destroy**

Height \_\_\_\_\_ cm      Weight \_\_\_\_\_ kg

Allergies \_\_\_\_\_

<b>SCS GIMRAC (GIM Rapid Assessment Clinic) Referral (ED) Order Set</b>		<b>M</b>	<b>K</b>	<b>O</b>
Orders Processed Date (dd/mm/yyyy)	<b>Diagnostics - Cardiology</b>			
	<input type="checkbox"/> Syncope/Heart Failure/Chest Pain/Palpitations: <input type="checkbox"/> ECG			
Time (hhmm)	<b>Clinical History</b>			
	_____			
	_____			
	_____			
By	<b>Prior to Leaving ED</b>			
	<input checked="" type="checkbox"/> RN, please document on this form patient's preferred contact for appointment booking Name/Relation: _____      Contact Number: _____			
Status	<input checked="" type="checkbox"/> Advise patient/caregiver to call 905-378-4647 x44150 if no appointment booked in 2 business days			
	<b>Additional Orders</b>			
	_____			
Processing Reviewed by	_____			
	_____			
	_____			
Status	<b>Ordering Physician Information</b>			
	Physician Billing Number: _____			
Faxed by	_____			

Telephone Order \_\_\_\_\_  
 Ordering Practitioner, Designation      Signature      Date/Time (dd/mm/yyyy hhmm)

If Telephone Order \_\_\_\_\_       Read Back  
 Ordering Physician      Date (dd/mm/yyyy)      Time (hhmm)



**Chart Copy – Do Not Destroy**