

## **Out-of-Province Referral Request for Approval Form**

This form is to be completed by the referring specialist physician within your province of residence. Please complete all sections and send to: Group Medical Services, 2055 Albert Street, PO Box 1949, Regina, SK S4P 0E3

| A. Patient Information  |           |                                       |   |                            |             |
|---|-----------|---------------------------------------|---|----------------------------|-------------|
| First Name  | Last Name |                                       |   | Date of Birth (DD/MM/YYYY) |             |
| Address   |           | City                                  |   | Province                   | Postal Code |
| GMS ID Number   |           | Family Physician/General Practitioner |   |                            |             |
| Address (Family Physician/ General Practitioner)  |           | City                                  |   | Province                   | Postal Code |
| Phone (Family Physician/ General Practitioner)  ( )   |           |                                       |   |                            |             |
| B. Referring Specialist Physician Information (specialist located in your province of residence)  |           |                                       |   |                            |             |
| Name of Referring Specialist Physician  |           |                                       |   |                            |             |
| Address   |           | City                                  |   | Province                   | Postal Code |
| Confirmed Diagnosis/Illness   |           |                                       | Date Medical Condition Diagnosed (DD/MM/YYYY) |                            |             |
| If no diagnosis has been confirmed and you are seeking a referral for a consultation only, please indicate the reason that this out of province consult is required. (please attach supporting documents) |           |                                       |   |                            |             |
| C. Out-of-Province Consulting/Treatment Information   |           |                                       |   |                            |             |
| Name/Credentials of Out-of-Province Specialist Physician  |           |                                       |   |                            |             |
| Investigation/Treatment/Surgery Required Out of Province of Residence   |           |                                       |   |                            |             |
| Is this surgery/treatment available in the patient's province of residence?  Yes No   |           |                                       |   |                            |             |
| Please Provide an Explanation:  |           |                                       |   |                            |             |
| City and Province Referred to:  |           |                                       |   |                            |             |
| Is this referral due to wait list times within the patient's province of residence?  Yes No   |           |                                       |   |                            |             |
| Referring Physician's Signature X   |           |                                       |   | Date (DD/MM/YYYY           | )           |

Please attach a copy of the letter of referral being sent to the out-of-province specialist.