VGH Hyperbaric Unit
855 West 12th Avenue
Blackmore Pavilion, Ground Floor
Vancouver, BC V5Z 1M9
Phone: 604-875-4033 Fax: 604-875-5294

CONSULTATION REQUISITION FORM

- **Please complete ALL SECTIONS of this form to the best of your ability.**
- **Patient history, all test results and the patient's current medication list must be sent along with this consultation request.**

PATIENT NAME: _____DOB: _____

PHN: _____

ADDRESS: _____

_____ EMAIL: _____

TELEPHONE NIMBER: (HOME) _____ (OTHER) _____

DIAGNOSIS: _____

REASON FOR REFERRAL: _____

_____

_____

_____

_____

FAMILY DOCTOR: _____ MSP# _____

PHONE: _____ FAX: _____

REFERRING DOCTOR: _____ MSP# _____

PHONE: _____ FAX: _____

SURGERY DATE ? NO ☐ YES ☐ DATE OF SURGERY _____

FOR THIS REQUEST TO BE PROCESSED, A RECENT AUDIOGRAM AND APPROPRIATE BACKGROUND INCLUDING YOUR ENT CONSULTATION MUST ACCOMPANY ALL CONSULT REQUESTS FOR SSHL PATIENTS

ATTACHED: ☐ Hx, ☐ CT scan, ☐ Labs, ☐ Ultrasound, ☐ Cardiac Echo, ☐ ECG, ☐ Nuc Med, ☐ Bx