Central Interior Rural
Primary Care Network

Patient Label

PRIMARY CARE NETWORK REFERRAL
Central Interior Rural

Referral Date _____

Patient Last Name _____ Patient First Name _____

Preferred Name _____ Birth Sex _____ Legal Sex _____

DOB _____ PHN _____ Preferred Pronoun _____

Primary Care Provider _____ Email _____

Address _____ Clinic Name _____

Home Phone _____ Cell Phone _____ City _____

Name of Referral Source _____ Phone Number of Referral Source _____

Name of Person to Contact (if other than patient) _____

Does client self identify as Aboriginal/Indigenous? If yes, check one:

☐ First Nations Status ☐ First Nations Non Status ☐ Métis ☐ Inuit ☐ Other

Referral to PCN

- ☐ Respiratory Therapist
- ☐ Clinical Pharmacist
- ☐ Social Worker (WL)
- ☐ Social Worker (100 Mile)
- ☐ Mental Health Clinician (WL)

Reason for Referral	

Send referral of the fax number below:

PCN Hub	Phone	Fax
	250-296-0070	844-961-3410