

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 <i>(specialist located in your province of residence)</i>			
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. <i>(please attach supporting documents)</i>			
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.