

Surgical Slating Form-Elective

SLATING TO STAMP WHEN THE	Y
RECIEVE	

urgeon:		Date of r	eferral receive	ed·		
	Date of referral received: Elinic - Family PhysicianReferring Physician					
Patient's Last Name:						
Date of Birth:						
Address:			Postal c	ode:		
Contact Number:		Work nun	nber:			
Emergency Contact:				Contact#		
Height:Weight						
Alerts: □ Diabetic □ Allerg	ies					
o be completed by Surgeon:	:					
Decision to treat (Date of Surg	gical Consent):		Γ	□ sds □ ou	T/ADM 🗆 INPT	
Admitting Physician				tist Consult Req	uired: 🗌 Yes 🗌	
Diagnosis:						
Surgical Procedure:						
Second Joint \square Yes \square No	Second Eye: \Box] Yes □ No				
Additional Information: Priority:	2 weeks) □ Urgent (< 4	4 weeks) □ Semi-U	rgent (< 6 we		(< 26 weeks)	
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