Group Medical Services

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	Date *(DD/MM/YYYY)*
X	

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