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 submit to Claims at *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 No.	Family Physician/General Practitioner		
Address *(Family Physician/General Practitioner)*	City	Province	Postal Code
Phone *(Family Physician/General Practitioner)* ( )			

B. Referring Specialist Physician Information *(located within 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 Referring Specialist Physician	
Confirmed Diagnosis/Illness	Date Medical Condition Diagnosed *(DD/MM/YYYY)*
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 and 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 Signature **X**	Date *(DD/MM/YYYY)*

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

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Group Medical Services • 2055 Albert Street PO Box 1949 Regina SK S4P 0E3 • 1.800.667.3699 • www.gms.ca

Group Medical Services is the operating name for GMS Insurance Inc.