CLINIC NAME / NOM DE LA CLINIQUE
Address / Adresse:
Phone / Tél: Fax / Téléc:

PRESCRIPTION / ORDONNANCE

Patient name / Nom du patient: _____
Date of birth / Date de naissance (YYYY-MM-DD): _____
RAMQ Health Card # / N° carte soleil: _____
Address / Adresse: _____
_____

Date: ____ / ____ / _____ (YYYY-MM-DD)

Medication / Médicament: _____
Strength / Force: _____
Form (tab, cap, soln, etc.): _____

Sig (directions / posologie):
_____
_____

Quantity / Quantité: _____
Refills / Renouvellements: _____

Indication (optional / facultatif):
_____

Allergies: _____

_____

Prescriber / Prescripteur:
Name / Nom: _____
License / Permis: _____
Specialty / Spécialité: _____
Address: _____
Phone / Tél: _____ Fax: _____

Signature: _____

CLINIC / HOSPITAL LABORATORY REQUISITION
DEMANDE D'ANALYSES DE LABORATOIRE

A. PATIENT INFORMATION / RENSEIGNEMENTS SUR LE PATIENT
Patient name / Nom: _____
Date of birth / Date de naissance: _____
Sex / Sexe: ☐ M ☐ F ☐ Other
RAMQ Health Card #: _____
Phone / Tél: _____
Address / Adresse: _____
_____

B. ORDERING PHYSICIAN / MÉDECIN DEMANDEUR
Name / Nom: _____
License / Permis: _____
Clinic: _____
Phone / Tél: _____ Fax: _____
Copy to (Dr) / Copie à: _____

C. TESTS REQUESTED / ANALYSES DEMANDÉES
☐ CBC
☐ Electrolytes (Na, K, Cl, CO2, Cr, BUN)
☐ LFTs
☐ Lipid profile
☐ Fasting glucose / HbA1c
☐ TSH
☐ Urinalysis
☐ Pregnancy test (β-HCG)
☐ Coagulation (PT/INR, aPTT)
☐ Other / Autre:
_____
_____

D. SPECIMEN / SPÉCIMEN
Collection date & time / Date et heure de prélèvement:
____ / ____ / _____ _____:_____ (24h)

Specimen type / Type: ☐ Blood ☐ Urine ☐ Stool ☐ Swab
Fasting / À jeun: ☐ Yes / Oui ☐ No / Non

E. CLINICAL INFORMATION / INFORMATIONS CLINIQUES
Provisional diagnosis / Dx provisoire:
_____
Relevant history / Histoire pertinente:

_____
_____

F. BILLING / FACTURATION
☐ RAMQ ☐ CNESST (work injury)
☐ SAAQ (auto) ☐ Private / Privé

RAMQ Health Card # (if not above): _____

Physician signature / Signature du médecin: _____
Date: ____ / ____ / _____

[Clinic Letterhead / En-tête de la clinique]

Date: ____ / ____ / _____

To / À:
Dr _____
Specialty / Spécialité: _____
Address / Adresse: _____
_____

Re: [PATIENT NAME], [DOB], RAMQ: _____

Dear Dr _____, / Bonjour Dr _____,

I am referring [patient name], a [age]-year-old [man/woman/person], for assessment of: [main reason for referral].

PRESENTING ISSUE:
- Onset and course:
  _____
- Key symptoms:
  _____
- Impact on function:
  _____

RELEVANT MEDICAL HISTORY:
- Past medical history:
  _____
- Surgical history:
  _____
- Medication list:
  _____
- Allergies:
  _____
- Family history:
  _____
- Social history (smoking, alcohol, occupation, etc.):
  _____

INVESTIGATIONS TO DATE:
- Labs:
  _____
- Imaging:
  _____

- Other tests / consultations:
  _____

TREATMENT TO DATE AND RESPONSE:
_____
_____

SPECIFIC QUESTIONS / REQUEST:
- Please assess for:
  _____
- Please consider:
  _____

Thank you very much for seeing this patient.

Sincerely / Veuillez agréer, Dr _____,

_____
Physician name / Nom du médecin
License / Permis:
Clinic:
Phone / Tél:
Fax:

PATIENT NOTE / NOTE CLINIQUE – SOAP

Date & time / Date et heure: _____
Clinician / Clinicien: _____
Location / Lieu: _____
Visit type: ☐ New / Nouveau ☐ Follow-up / Suivi

Patient: _____ DOB: _____
RAMQ #: _____

S – SUBJECTIVE
Chief complaint / Motif de consultation:
_____

History of present illness (HPI) / HMA:
- Onset:
- Location:
- Duration:
- Characteristics:
- Aggravating/relieving:
- Associated symptoms:

_____
_____

Past medical history (PMH) / ATCD médicaux:
_____

Medications / Médication:
_____

Allergies:
_____

Family history (FH) / ATCD familiaux:
_____

Social history (SH) / Habitudes de vie:
_____

O – OBJECTIVE
Vital signs:
- BP: _____ HR: _____ RR: _____
- Temp: _____ SpO2: _____ Weight: _____

Physical exam / Examen physique:
- General:
- HEENT:
- Cardio:
- Respiratory:
- Abdomen:
- Neuro:
- MSK:
- Skin:

_____
_____

Investigations today (labs / imaging / tests):

_____

A – ASSESSMENT
Working diagnosis / Diagnostic principal:

_____

Differential diagnoses:
1) _____
2) _____
3) _____

P – PLAN
1) Investigations:
_____
2) Treatment (medications, procedures):
_____
3) Referrals:
_____
4) Patient education / counselling:
_____
5) Follow-up:
_____

Safety / red flags discussed:

_____

Physician signature / Signature: _____

RAMQ PHYSICIAN SERVICES CLAIM
RÉGIE DE L'ASSURANCE MALADIE DU QUÉBEC – RÉCLAMATION MÉDICALE

A. PHYSICIAN INFORMATION / MÉDECIN
Name / Nom: _____
RAMQ permit number / N° de permis: _____
Specialty / Spécialité: _____
Billing number (if applicable): _____
Clinic or institution / Établissement: _____
Address / Adresse: _____
_____

B. PATIENT INFORMATION / PATIENT
Name / Nom: _____
RAMQ Health Insurance # / N° carte d'assurance maladie:
_____
Date of birth / Date de naissance: _____
Sex / Sexe: ☐ M ☐ F ☐ Other

C. SERVICE DETAILS / DÉTAILS DU SERVICE
Date of service / Date du service: ____ / ____ / _____
Time (if required) / Heure: _____:_____
Location code / Lieu (GMF, CLSC, hospital, etc.): _____
Episode type:
☐ Outpatient / Externe ☐ Inpatient / Hospitalisé
☐ ER / Urgence ☐ Telemedicine / Télémédecine

D. ACTS BILLED / ACTES FACTURÉS
(One line per act / Un acte par ligne)

1) Service code / Code d'acte: _____
Modifiers (if any) / Modificateurs: _____
Diagnosis code (ICD) / Code diagnostic: _____
Units / Unités: ____
Fee / Honoraires: _____ $

2) Service code / Code d'acte: _____
Modifiers: _____
Diagnosis code: _____
Units: ____
Fee: _____ $

3) (Add more lines as needed)

E. OTHER INFORMATION / AUTRES RENSEIGNEMENTS
Accident-related? / Accident?
☐ No / Non ☐ Work (CNESST) ☐ Auto (SAAQ)

Referring physician number (if applicable):
N° médecin référant: _____

Comments / Remarques:
_____
_____

F. PHYSICIAN DECLARATION / DÉCLARATION DU MÉDECIN
I certify that the above services were personally rendered
as claimed, in accordance with RAMQ rules.

Je déclare que les services indiqués ont été rendus
conformément aux ententes en vigueur avec la RAMQ.

Physician signature / Signature du médecin: _____
Date: ____ / ____ / _____