



## Nurse Practitioner Consultation and Referral Statement

**Section A** To be completed by the Nurse Practitioner and forwarded to the employer and/or physician(s) with whom the arrangement for consultation, referral and transfer of any patient has been made.

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Surname Given Name Registration #

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Street City Province Postal Code

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Telephone Number Email

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Employer Name and Facility

**Section B** To be completed by employer and/or physician. Please return directly to the Nurses Association of New Brunswick.

This is to confirm that the above named person in my employ has access to a medical practitioner for consultation, referral or transfer of any patient

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Authorized signature DD/MM/YY

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Title

**and/or**

This is to confirm that the above named person has an arrangement with me for consultation, referral or transfer of any patient.

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Physician's Name Signature

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Address

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DD/MM/YY Telephone Number