NANB

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.**

Surname | Given Name | Registration #

Street | City | Province | Postal Code

Telephone Number | Email

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**

Authorized signature | DD/MM/YY

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.**

Physician's Name | Signature

Address

DD/MM/YY | Telephone Number

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E-mail: nanb@nanb.nb.ca / Web: www.nanb.nb.ca

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