

REFERRAL FOR CONSULTATION

Patient Name _____
DOB _____
Patient Contact Info _____
OHIP # _____

Date Prepared: ___/___/___ (yy/mm/dd)

Tel: _____ Fax: _____

URGENT/ timing: _____ Non-urgent As per availability

REASON for REFERRAL		
Referral To: _____	Tel: _____	Fax: _____
Address: _____		
Referral for <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Hypertension <input type="checkbox"/> Other: _____		
Reason(s): _____		
New Problem(s) relevant to this request:		
1. _____		
2. _____		
Questions/Expectations:		
1. _____		
2. _____		
Relevant Patient Data		
_____ years since diagnosis of _____		
Relevant Medications/Treatment:		
1. _____ <input type="checkbox"/> in use since ___/___/___ <input type="checkbox"/> discontinued since ___/___/___		
2. _____ <input type="checkbox"/> in use since ___/___/___ <input type="checkbox"/> discontinued since ___/___/___		
3. _____ <input type="checkbox"/> in use since ___/___/___ <input type="checkbox"/> discontinued since ___/___/___		

Relevant Investigations & Procedures:		
1. _____		
2. _____		
Other Relevant Information: _____		

Consultant

PLEASE COMPLETE BOX BELOW & FAX BACK TO:

APPOINTMENT INFORMATION	
Appointment Date: ___/___/___ (yy/mm/dd)	Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Special Instructions to Patient:	
<input type="checkbox"/> bring health card <input type="checkbox"/> bring diagnostic reports/results <input type="checkbox"/> bring medications <input type="checkbox"/> bring X-rays	
<input type="checkbox"/> other: _____	
We have informed the patient of appointment : <input type="checkbox"/> Yes <input type="checkbox"/> No, please advise patient	

Thank you. _____
Referral Faxed on: ___/___/___ Patient has been informed of appointment

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