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 ☐ Asthma ☐ Diabetes Mellitus ☐ Hypertension ☐ 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. _____ ☐ in use since __/__/__ ☐ discontinued since __/__/__
2. _____ ☐ in use since __/__/__ ☐ discontinued since __/__/__
3. _____ ☐ in use since __/__/__ ☐ 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:** _____ ☐ a.m. ☐ p.m.

Special Instructions to Patient:
☐ bring health card ☐ bring diagnostic reports/results ☐ bring medications ☐ bring X-rays
☐ other: _____

We have informed the patient of appointment : ☐ Yes ☐ No, please advise patient

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

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