

REFERRAL FORM

Date: / /
 YYYY/MM/DD

Name: _____
 DOB: _____
 HC#: _____
 Telephone: _____
 Address: _____
 MRN/Visit # (UHN only) _____

Referral Physician Expectations:

- One time consultation
- Consider ongoing co-management for this issue(s)
- Urgent appointment requested
- Next available appointment **OR**
- Specific MD _____
- Other: _____

Referral From:

- Family Medicine
- Emergency
- Post-discharge
- Community Care Access Centre (CCAC)
- Ambulatory Internal Medicine Group Practice Sub-specialty
- Virtual Ward/Clinical Decision Unit

Hospital/Site:

- WCH
- TWH
- TGH
- Other: _____
- UHN Visit #: _____

Referring Physician:

Referring Physician OHIP Billing Number: _____

Referring Physician Telephone Number: _____

Referring Physician Fax Number: _____

Family Physician (if different than referring): _____

Family Physician Fax Number: _____

Interpreter needed Yes No

Language: _____

Main reason for referral/most important issue(s) for the patient:: _____

What other service/specialties has this patient seen for this issue(s) (if any)? Not applicable

Co-morbidities: _____

Attach all relevant documentation available including imaging, labs, discharge summaries, consultation letters, and pathology. Identify any critical results below: _____

Attachments Yes No

Specify if you recommend that your patient also needs to be assessed by a member of our inter-professional team:

- Respiratory Therapist
- Nurse
- Occupational Therapist
- Pharmacist
- Physiotherapist
- Social Worker
- Dietitian
- CCAC
- Mental Health

Rationale:

Print Name: _____ Signature _____ Designation _____

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F-2427 (11-2011) **PLEASE FAX COMPLETED REFERRAL TO 416-323-7739** Page 1 of 1