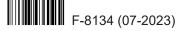


	Sex: Date of	Birth: / /
Tel: 416-323-7559 x 4 Fax: 416-323-7739	Address:	DD / MM / YYYY
NEPHROLOGY REFERRAL FOR	2M	
URGENCY: ☐ Routine ☐ Semi-Urgent ☐ Urgent REFERRAL DATE:/ DD / MM / YYYY	Telephone:	
SPECIFIC PHYSICIAN: \(\subseteq \text{No (First Available)} \)	s (Dr)
ADDITIONAL PATIENT INFORMATION		
Preferred name:	WCH Medical Record Numb	er (if known):
Gender: Pronouns: ☐ He/Him	☐ She/Her ☐ They/Them	☐ Other
Other insurance coverage (IFH, UHIP, etc.):		☐ Self-pay
Language spoken:	Interpreter requ	ired: Yes No
Allergies:		
REFERRING PROVIDER INFORMATION		
Name: Address:	Billing #:	
Telephone: Fax:	Signature:	
☐ Referring Provider is not the Primary Care Provider Primary Care Provider Name: Primary Care Provider Telephone:		
REASON FOR REFERRAL		
□ Acute Kidney Injury □ Chronic Kidney Disease □ Hypertension □ Electrolyte Abnormality □ Other: Additional Comments:		Please attach any relevant: Abdominal imaging Kidney imaging
FAMILY AND MEDICAL LUCTORY		
FAMILY AND MEDICAL HISTORY Current Conditions:		
Past Medical History:		
Medications:		
Family History:		

Name:

PATIENT INFORMATION (Affix Patient Label/Identification Here)

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