



WOMEN'S COLLEGE HOSPITAL 76 Grenville Street
 Toronto, Ontario
 Healthcare | REVOLUTIONIZED M5S 1B2

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ALLERGY REFERRAL FORM

URGENCY: Routine Semi-Urgent Urgent

REFERRAL DATE: / /
 DD / MM / YYYY

PATIENT INFORMATION

(Affix Patient Label/Identification Here)

MRN: _____ HCN: _____

Name: _____

Sex: _____ Date of Birth: _____ / _____ / _____
 DD / MM / YYYY

Address: _____

Telephone: _____ Alternate #: _____

ADDITIONAL PATIENT INFORMATION

Preferred name: _____ WCH Medical Record Number (if known): _____

Gender: _____ Pronouns: He/Him She/Her They/Them Other: _____

Other insurance coverage (IFH, UHIP, etc.): _____ Self-pay

Language spoken: _____ Interpreter required: Yes No

Allergies: _____

REFERRING PROVIDER INFORMATION

Name: _____ Billing #: _____

Address: _____

Telephone: _____ Signature: _____

Fax: _____

Referring Provider is not the Primary Care Provider

Primary Care Provider Name: _____

Primary Care Provider Telephone: _____

REASON FOR REFERRAL

ADDITIONAL INFORMATION

Current conditions: _____

Past medical history: _____

Current medications: _____

Family history: _____

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