REFERRAL FORM

PATIENT INFORMATION

Name:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Birth date (MM/DD/YYYY):	Sex: ☐ M ☐ F
Address:	Health no.:		Home phone no.:	
P.O. box: / City:	Province:		Postal Code:	

REFERRING PHYSICIAN

Name:	Phone no.:	Best Time to call:
Address:	Fax no.:	
	E-mail:	
P.O. box: / City: / Province:	Postal Code:	

CONSULTING PHYSICIAN

Name:	Phone no.:	Best Time to call:
Address:	Fax no.:	
	E-mail:	
P.O. box: / City: / Province:	Postal Code:	

Urgency of Referral:	Type of Consultation Requested:
☐ Urgent (< 1 week) ☐ Semi-Urgent (1-3 weeks) ☐ Routine (> 3 weeks)	☐ One time ☐ Shared Care ☐ Transferred Care

CLINICAL INFORMATION

Reason for referral / Expected outcome (ie. assessment, investigation, treatment, second opinion):

Diagnosis: ☐ Confirmed ☐ Provisional ☐ Not yet diagnosed

History of presenting complaint / examination findings / investigation results :

Past Medical History / Problem List:

Current and recent medication (including OTC)**:**

Clinical Warnings (allergies, blood-born diseases, other risk factors) :

Special Considerations / other relevant information (psychosocial, special needs, language issues) :

☐ Copy of test results and old notes included Specifically:	_____ **Signature of Referring Physician** **Date (MM/DD/YYYY)**

Thank you for this consultation.