PATIENT REFERRAL FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

HEALTH CARD #: _____

PHONE #: _____

ADDRESS: _____

REFERRING PHYSICIAN NAME: _____

REFERRING PHYSICIAN OHIP BILLING #: _____

OFFICE PHONE #: _____

FAMILY PHYSICIAN'S NAME (IF DIFFERENT FROM REFERRING MD):

_____

REASON FOR REFERRAL:

Please include any pertinent investigations such as ECGs, echocardiograms, stress tests, Holter reports and recent blood work if available.

FAX REFERRALS TO 647-748-4859

REFERRING PHYSICIAN'S SIGNATURE:_____

DATE: _____