Physician Referral Form

18 years of age or older

Patient's email address: _____

Physician's email address: _____

Information- Healthcare Provider Name, Address, Phone, Fax etc.	Information- Patient Name, DOB, OHIP #Address, Contact

Referring Provider (Primary care provider, Specialist, other):

_____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Complaint of Pain since: _____

Reason for this referral: _____

Is the patient on blood thinners? Yes☐ No☐. If yes, please provide name:

The following documents are attached with the referral in order to expedite:

☐ Copy of Patient's Profile/Patient's Medical History

☐ Relevant reports for e.g. consultation notes, imaging, operative

☐ List of current medications

I hereby acknowledge, I am referring this patient for consultation and potential treatment, and agree to continue providing care for this patient following their discharge.

Signature (Healthcare Provider): _____

Date: _____