NOTE: Incomplete and / or unsigned requistions will be returned

Community Health Clinic Referral

Please Fax To: **1-833-664-4807**

Telephone: **905-472-7658**

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN #: ______

Patient Name: ______ (Last) (First)

Date of Birth: ______ (Day) (Month) (Year) Sex: F M

Health Card # ______ Version Code: ______

☐ WSIB Claim #: ______ ☐ Non OHIP, Self-pay or Refugee

Telephone # (Best Daytime): ______

Alternate #: ______

Date	**Referring MD/NP**	**Signature**	**Telephone**
CPSO #	**Billing #**	**Address**	**Fax**

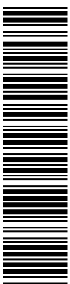
Additional Reports to:

Preferred Language	Name & number of for interpreter to help schedule appointment, if available

Does patient have a primary provider? ☐ Yes ☐ No If yes: ______

Referral Request From:

- ☐ Transgender Affirming Clinic
- ☐ Primary Care walkin, FHO, FHT
- ☐ CAMH
- ☐ EMS
- ☐ Public Health
- ☐ Newborn Clinic
- ☐ GIM
- ☐ Adult Diabetes
- ☐ ED
- ☐ Other: ______
- ☐ OVH Inpatient
- ☐ Surgery
- ☐ Paediatrics
- ☐ Rapid Access Clinic for Low Back Pain



Reason for Referral:

______

______

Clinical Information:

______

______

Current Medication: ______

______

Completed Tests / Procedures: ☐ X-ray ☐ MRI ☐ CT ☐ LAB

☐ Others: ______

Please attach any supporting documents