MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Proud member of
East Toronto Health Partners

MEDICAL ASSESSMENT CLINIC REFERRAL FORM

TEL: (416) 469-6252 FAX: (416) 469-6253

REF

☐ **Routine** ☐ **Urgent**

Patient ID Label

Date:

Patient Last Name:	Given Name: ☐ M ☐ F	Date of Birth: (DD / MMM / YYYY)
Address:	Apt#:	Telephone Number – Primary Number: ( )
Town or City:	Province: Postal Code:	Telephone Number – Alternate Number: ( )
Contact Person (Caregiver/Parent/Guardian:	Relationship To Patient:	Telephone Number - Contact Person: ( )
Family Physician:	**Ontario Health Card Number:** Version Code	**Email Address For Virtual Consult:**

Height (cm):	Weight (kgs):	Allergies: ☐No ☐Yes ☐Unknown

Required Questions:		
	PRIVACY: If we call the patient, can we leave a voice message?	☐No ☐Yes
	WSIB: Is this treatment due to a work related injury?	☐No ☐Yes
	American Sign Language interpreter required?	☐No ☐Yes
	Language interpreter required? - specify:	☐No ☐Yes

Referred To:	☐ **First Available Appointment** (within 14 days) ☐ Patient has previous visits with a Medical Assessment Physician: Name of Physician _____	**Referral Date:**

Reason For Referral:

IMPORTANT!

Please send all pertinent lab reports & diagnostic test reports.

If you have scheduled an diagnostic test, please record the date of the appointment.

Neurological Issues:
- ☐ Ataxia
- ☐ Weakness
- ☐ Parkinson's
- ☐ Stroke
- ☐ Vertigo
- ☐ Bell's Palsy
- ☐ Seizure

- ☐ Hypertensive urgency
- ☐ Lymphadenopathy
- ☐ New onset CHF
- ☐ New/worsening Ascites/cirrhosis
- ☐ Undifferentiated dyspnea
- ☐ Edema
- ☐ Cellulitis
- ☐ Rash/skin lesion not yet diagnosed

- ☐ Chronic Fever, unknown origin
- ☐ Diabetic foot infection
- ☐ Leg/foot ulcers
- ☐ Rheumatologic complaints (e.g. gout, acute monoarthritis)
- ☐ Uncontrolled Diabetes
- ☐ Weightloss
- ☐ Abdominal Pain not yet diagnosed

Other reasons for referral:

Investigations To Date:
☐ Ultrasound ☐ Lab Tests ☐ Pathology Reports ☐ Procedures Notes ☐ Consultation Notes
☐ Other Tests:

Past Medical History:

Medication Name	Dose:	Frequency:

Referring Physician:	Physician Name:	Physician Email:
	Telephone Number: ( )	Fax Number: ( )
	Physician's Signature:	Billing#:

MGH Appointment Information:	

Ocean by CognisantMD — Ontario eServices Program

We now accept Ocean eReferrals for various clinics. The best way to find Specialist and refer your patients. For more information and to sign-up for your Ocean user account, contact Ontario eHealth at **eReferral@ehealthce.ca**