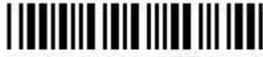


# OUT-PATIENT SERVICES CLINIC REFERRAL FORM



REF

*Patient Label*

Patient Last Name:		Given Name:		Date of Birth: (Day / Month / Year)	
Address:			Apt#:		Telephone Number - Home: ( )
Town or City:		Province:	Postal Code:		Telephone Number - Cellphone: ( )
Contact Person / Caregiver / Guardian:			Relationship To Patient:		Telephone Number - Contact Person: ( )
Family Physician:		Ontario Health Card Number:		Version Code	Hospital Patient ID No. / MRN:

<b>Required Questions:</b>	<b>WSIB</b>	- Treatment due to a work related injury?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	<b>INTERPRETER</b>	- Language interpreter required?	<input type="checkbox"/> No	<input type="checkbox"/> Yes - If YES, language:
	<b>PRIVACY</b>	- American Sign Language interpreter required?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
		- May we call the patient or leave a message?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If NO, who can we contact? Name:				Tel:

<b>Referred To:</b>	Clinic / Service:	Specialist/Clinician Name:
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<b>Reason For Referral:</b>  <b>IMPORTANT PLEASE READ:</b>  INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION  PLEASE SEND <u>ALL</u> PERTINENT LAB/ DIAGNOSTIC RESULTS AND A LIST OF CURRENT MEDICATIONS  REFERRALS FOR FRACTURE CLINIC PATIENT SHOULD BRING WITH THEM THE CD OR X-RAY FILMS IF THE TESTS WERE NOT COMPLETED AT THIS HOSPITAL				
Was patient previously treated by this Clinician? <input type="checkbox"/> No <input type="checkbox"/> Yes	Onset Date:	Injury Date:	Date of Surgery:	Last Admission Date:

<b>Referring Physician:</b>	Physician Name:		Telephone Number: ( )	
	Referring Clinic Name:		Fax Number: ( )	
	Physician's Signature:		Billing#:	Date: