MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

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:**

Required Questions:	**WSIB**	- Treatment due to a work related injury?	☐No	☐Yes
	INTERPRETER	- Language interpreter required?	☐No	☐Yes - If YES, language:
		- American Sign Language interpreter required?	☐No	☐Yes
	PRIVACY	- May we call the patient or leave a message?	☐No	☐Yes
		If NO, who can we contact? Name:		Tel:

Referred To:	Clinic / Service:	Specialist/Clinician Name:

Reason For Referral:

IMPORTANT
PLEASE READ:

INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION

PLEASE SEND ALL 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? ☐No ☐Yes	Onset Date:	Injury Date:	Date of Surgery:	Last Admission Date:

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