JOSEPH BRANT HOSPITAL

Infectious Diseases Clinic Referral Form

1245 Lakeshore Road, Burlington, ON L7S 0A2
Telephone: 905.336.4110 | Fax: 905.681.4879

TO REQUEST AN APPOINTMENT: Please fax the completed referral and all requested clinical information.
Please notify your patient of appointment date, arrival time and instructions.

Medical Record #: _____ Patient Name: _____

Address: _____ DOB: _____ Age: _____ ◯ Female ◯ Male

OHIP #: _____ Version Code: _____

Location

☐ Home ☐ Hospital ☐ Longterm Care Facility Preferred contact: _____

☐ Interpreter required Language: _____ Physical/Other limitations: _____

ALLERGIES: _____

IPAC Screening

☐ VRE ☐ MRSA ☐ ESBL

☐ Clostridium difficile

☐ NO resistant organism

Referral Information

Appointment Type: ◯ New ◯ Follow-Up Urgency of Referral: ◯ Less than 2 weeks ◯ Greater than 2 weeks

Reason for Referral:

Antibiotics (Current, recent for current illness, dates):

Please include the following

☐ History of current issue
☐ Relevant consult and/or operative notes
☐ Full medication list
☐ Past medical history

Relevant Investigations (include copies)

☐ Microbiology (ie Bacteriology, Virology, Serology)
☐ Laboratory
☐ Radiology
☐ Other

Referring Physician Information

Physician Name: _____ Physician Billing Number: _____

Date: _____ Fax: _____ Physician Signature: _____

OFFICE USE ONLY

Appointment Date (d/m/y): _____ Time: _____ Clinic: _____

Notification (d/m/y): _____ ☐ Referring Office ☐ Patient ☐ Other: _____ Initials: _____

Isolation: _____

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