



1245 Lakeshore Road
Burlington, ON L7S 0A2

New Patient Referral Form Ambulatory Care

Telephone: 905.336.4110

Fax: 905.681.4879

Medical Record #: _____

Patient Name: _____

Address: _____

DOB: _____ Age: _____ Female Male

OHIP #: _____ Version Code _____

Phone#: _____ Cell: _____

Patient Email Address: _____

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

PATIENT LOCATION

Home Hospital Nursing Home

Other: _____

Preferred contact: _____

CONSIDERATIONS

ARO: VRE MRSA Other: _____

Language Interpreter required Physical limitations

Other: _____

REFERRAL INFORMATION

Reason for Referral:

Clinic Requested:

Dental Fracture GIMRAC
 Heart Function Pacemaker Stroke Prevention
 Thrombosis Vascular Women's Health
 Speech-Language Pathology: Communication Swallowing

Prior Hospital admission (past two years?) No Yes

(If yes provide details)

Surgical Procedure/Date: _____

Is this referral Urgent? No Yes

If Yes:

24 hr 48 hr 72 hr 1 wk

Reason for Urgency:

Relevant Clinical Information:

Patient History & Consult notes

Lab (pending No Yes)

Operative Reports

Other: _____

Any previous diagnostics: No Yes

If so please indicate where and include report:

CT MRI X-ray

US Angiogram ECG

Other _____

Have further tests been ordered? If so: _____

REFERRING PHYSICIAN INFORMATION

Referring Physician Name: (Please print)

Referring Physician Billing Number:

Referring Physician Signature:

Referring Physician fax:

Date:

OFFICE USE ONLY

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

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

14/01/2021



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