



1245 Lakeshore Road  
Burlington, ON L7S 0A2

**Infectious Diseases Clinic Referral Form**  
**Ambulatory Care**

Telephone: 905.336.4110  
Fax: 905.681.4879

Medical Record #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male

OHIP #: \_\_\_\_\_ Version Code \_\_\_\_\_

**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.**

**PATIENT LOCATION**

Home  Hospital  Longterm Care Facility

Preferred contact: \_\_\_\_\_

Interpreter required Language: \_\_\_\_\_

Physical/Other limitations \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

**IPAC SCREENING**

**Patient has tested positive for:**

VRE  MRSA

ESBL  *Clostridium difficile*

NO resistant organism

**REFERRAL INFORMATION**

Appointment Type:  New  Follow-Up

Reason for Referral:

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

Urgency of Referral:  ≤ 72 hours  > 72 hours and < 2 weeks  > 2 weeks

**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**

Referring Physician Name: (Please print)

Referring Physician Billing Number:

Referring Physician Signature:

Referring Physician fax:

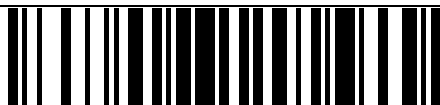
Date:

**OFFICE USE ONLY**

Appointment Date (d/m/y): \_\_\_\_\_ Time: \_\_\_\_\_ Clinic: \_\_\_\_\_

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

Isolation: \_\_\_\_\_



21/08/2020

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