JOSEPH BRANT HOSPITAL

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	**IPAC SCREENING**
☐ Home ☐ Hospital ☐ Longterm Care Facility **Preferred contact**: _____ ☐ Interpreter required Language: _____ ☐ Physical/Other limitations _____ **ALLERGIES:** _____	**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:	**Relevant Investigations (include copies)**:
☐ History of current issue	☐ Microbiology (ie Bacteriology, Virology, Serology)
☐ Relevant consult and/or operative notes	☐ Laboratory
☐ Full medication list	☐ Radiology
☐ Past medical history	☐ 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: _____

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21/08/2020