NORTH YORK INFECTIOUS DISEASE & INTERNAL MEDICINE

Tel: 416-247-4947 Fax: 365.525.2000
bookings@gmdclinic.ca
2221 Keele Street, Suite 301
North York, ON
M6M 3Z5

REFERRAL FORM CAN BE FAXED THROUGH TO 1.365.525.200

Date of Referral:_____ **Urgent:** ☐ **Yes** ☐ **No**

Patient Full Name:_____

Patient Address:_____

Health Card Number:_____

Patient Phone Number:_____**Date of Birth:**_____

Referring Physician Name:_____**BILLING #:**_____

Tel:_____ **Fax:**_____ **Signature:**_____

Reason for the Referral

☐ HIV, Hepatitis, PJI, Endocarditis, TB ☐ Travel medicine ☐ STDs, syphilis ☐ GIM, HTN, DM

☐ Tick borne, PrEP Patients ☐ GIM, HTN, DM ☐ Fatty Liver Disease, Gallbladder issues

☐ Celiac ☐ Thyroid issues ☐ Other _____

Additional information:_____

If applicable, please include with the referral:

☐ Previous Blood Work ☐ Diagnostic Imaging ☐ Consultation Letters

Referring Physicians will be notified within 2 weeks of receipt and patient will be notified of the appointment directly.