INTERNAL MEDICINE CLINIC

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FAX REFERRAL FORM TO 1.365.525.2000

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

Patient Full Name:_____

Health Card Number:_____**Vers:**_____

Date of Birth :_____

Patient Phone Number:_____

Address:_____

Referring Physician Name:_____

BILLING #:_____

Tel:_____ **Fax:**_____

Address:_____

Signature:_____

Reason for referral:

_____

_____

If applicable, please include with the referral:☐ Previous Blood Work ☐ Diagnostic Imaging ☐ Consultation Letters

Additional Comments:_____

_____

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