

IMPORTANT:

- ★ Incomplete referrals will not be accepted
- ★ Some referrals may be declined based on referral criteria.

Does the patient speak English?

Yes No- specify language

**Note: Clinic does not provide interpreters

Referral Date:

PATIENT NAME: _____

DOB: _____ Male Female
yy / mm / dd

Health card #: _____
Version code

Address: _____

City Postal code

Primary Daytime #: _____

Alternate #: _____

Primary Parent/Guardian/contact: _____

Daytime #: _____

**Is Patient aware of this
referral?** Yes No

Non-pregnant

Pregnant LMP: _____

For all pregnant patients it is **MANDATORY** to provide the
Ultrasounds, CBC, Group +
Screen, Antenatal 1, Maternal
Screening Results **along with
referral.**

REASON FOR REFERRAL:

Significant medical or family history:

Please attach all relevant information (i.e. blood work, imaging studies, consultation letters, genetic test results, etc.) to help us triage more urgent referrals and appropriate appointment booking.

REFERRING DOCTOR: _____ **Physician billing #:** _____

Address: _____

Phone # _____ **Fax #** _____

Signature: _____ I agree this referral contains **all relevant** information.