General Site
4001 Leslie Street
Toronto, ON M2K 1E1
T 416.756.6000
nygh.on.ca

Family Medicine Obstetrics Referral Form

Date of Referral _______/_______/________ (DD-MM-YY)

PATIENT INFORMATION

Name: ____
Last *First* *Middle Name*

Birth Date: _______/_______/________ (DD-MM-YY)

Health Card Number: ______________________________Version Code: ___________

Address: ____

City: _________________________ Province: _______ Postal Code: __________

Home Phone: _________________May we leave a message: ☐ Yes ☐ No

Cell Phone: _________________ May we leave a message: ☐ Yes ☐ No

Email: ____
May we email: ☐ Yes ☐ No

REFERRING PHYSICIAN

Name: ____

Address: ____

Phone Number: ___________________ Fax Number: _________________________

OHIP Billing Number: ____

Reason for Referral: ____

____

Shared Care: ☐ Yes ☐ No
Newborn Care: ☐ Yes ☐ No

Please fax referral and any relevant documentation to:
Family Medicine Obstetrics, North York General Hospital, Department of Family & Community Medicine, 4001 Leslie Street Toronto, M2K 1E1
Tel: (416)756-6019
Fax: (416) 756-6822

Making a World of Difference