NORTH YORK GENERAL

General Site
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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

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