CREDIT VALLEY SURGICAL – PHYSICIAN REFERRAL FORM

website: creditvalleysurgical.ca email: info@creditvalleyclinic.ca

□ Dr. Azin □ Dr. Bard □ Dr. Burns □ Dr. Hosein □ Dr. Kumar □ Dr. Tawadros □ Dr. Woolfson

PATIENT INFORMATION (please complete or attach label)

Name: _____ DOB: _____ M/F

Address: _____

_____

Health Card Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

REASON FOR REFERRAL:

_____

_____

_____

PAST MEDICAL/SURGICAL HISTORY:

_____

_____

_____

_____

MEDICATIONS (please include all prescription meds including blood thinners):

_____

_____

_____

INVESTIGATIONS DONE (please include ALL relevant IMAGING RESULTS)

_____

_____

_____

REFERRING PHYSICIAN INFORMATION:

Name: _____ Referring Physician Number: _____

Phone: _____ Fax: _____

Signature: _____

FAX COMPLETED REFERRAL (INCLUDING ALL RELEVANT IMAGING/TEST RESULTS) TO 905-820-3352 or 905-820-4482 - referrals will be triaged and we will contact your patient