

REFERRAL FORM

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

First Last dd/mm/yy

Primary Phone Number: _____ **Patient Email address:** _____

OHIP Number including Version Code : _____

Primary Care Physician (name and fax) :_____

REASON FOR REFERRAL (please check one):

- ☐ Chronic/Problem Wound
 ☐ Sudden Sensorineural Hearing Loss
☐ Diabetic Foot Ulcer
☐ Refractory Osteomyelitis
 ☐ Non-Healing Surgical Wounds
☐ Compromised Flaps/Grafts Frostbite/Thermal Burns
 ☐ Exceptional Anemia
☐ Delayed Radiation Injury (indicate type of injury): _____
 ☐ Other _____
☐ Symptomatic early to mid stage AVN (covered by OHIP as of Apr. 1st)

History:

PLEASE INCLUDE ALL OF THE FOLLOWING INFORMATION WITH YOUR REFERRAL (if available):

- Most Recent Consult/Follow up notes
- Chest X-ray or CT
- Echocardiogram, ECG
- List of Medications, Allergies, Past Medical/Surgical History
- Recent Bloodwork including HbA1C, CBC, ESR/CRP
- ABI and other vascular studies
- Specialist reports (Cardiology, Resp, ENT, Derm, Ortho/Vascular Surgery)
- Other Relevant Diagnostic Imaging reports

REFERRING PHYSICIAN INFORMATION:

Name: _____ CPSO: _____

OHIP Billing #: _____

Tel: _____ Fax: _____

Signature: _____ Date: _____

Current MRP for wound care (if applicable): _____ Phone: _____