# URGENT MEDICAL CARE CLINIC – REFERRAL FORM

**Tel #416-242-1000 X23400 Fax: 416-242-1094 1235 Wilson Ave., Toronto, ON M3M 0B2**

Patient Name: ______________________________________ Date of Birth**:** ____________________ F ☐ M ☐

Address: ____________________________________________________________________________________

\# Street City Postal Code

Phone (1) #:____________________ (2) #:_________________ Language: ________________ Interpreter Yes☐No☐

OHIP #:_____________________________Version Code**:** _____ Family Physician**:** _____________________________

**Contact Person (i.e., Family Member, Power of Attorney, etc.):**__________________________________________

**Relationship:** _____________________________________ **Phone #** ___________________________________

**Reason for referral ***See back for criteria*****

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

**Urgency of appointment:** ☐**1-3 day(s) *Please call clinic** ☐**3-7 days** ☐**within 10-14 days**

☐ All relevant information - list of medications, investigations or reports not found in Humber River Hospital's EMR are attached?

☐ Pending diagnostics: ___________________________________________________________________

**Medical History:**

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

**Key findings & Examinations:**

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

☐ **Allergies:** _________________________________________________________________________________

**Referring Physician: (Print)** ____________________________________________ **CPSO#:** __________________

**Billing #** __________________ **Phone #** _______________________**Fax #** _________________________

**Signature:** _______________________________________ **Date:** ______________________________

*****Please remind patients to bring all medications to clinic appointment*****

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Form # 103163, version (10/2017)

**Example Criteria:**

- Patients that are unable to be seen by their Primary Care Practitioner (PCP) within 1-2 weeks of discharge from the Emergency Department or from an Inpatient Unit
- Patients that do not have a PCP and would have no follow-up post ED/Inpatient discharge
- High-risk: patients that have greater than 3 chronic conditions
- Benign Hematology (e.g. chronic anemia, thrombocytopenia)
- Follow-up with diagnostics or laboratory work ordered upon discharge
- Fever NYD
- Weight loss NYD
- Hypertension
- Abnormal x-ray

**Exclusion Criteria:**

Follow-up that may require the specialties listed below:

- Surgery
- Neurology
- Neurosurgery
- Oncology
- Hematology
- Cardiology
- Respirology
- Mental Health

**Please refer to the appropriate Outpatient Clinic