HEALTHY LIVING CLINIC (GERIATRIC MEDICINE) – REFERRAL FORM

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Section I: Patient Information

Date: ___________________ **Sex** F ☐ M ☐ **Date of Birth:** ____/____/____ (dd/mm/yyyy)

PATIENT NAME (print): Last: ___________________________________ First ___________________________________

ADDRESS: ____

Street City Postal Code

HOME PHONE #:_____________________________**OTHER PHONE#**:____

OHIP #:____**Version Code:** __________________________

FAMILY PHYSICIAN:____ **Language:**___________________

☐ **Interpreter Required Yes No**

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

Relationship: ____ **Phone #** _______________________________________

Section II - Services Requested

☐ **Clinic Visit** ☐ **Other**

*******WE WILL CONTACT PATIENT WITH APPOINTMENT*******

Reason for referral (attach any relevant information including medications, investigations or reports):

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Relevant background history (incl. names of all attending physicians if applicable):_____________________

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☐ **Allergies:** ____

Referring Physician: ____ **CPSO#:** ___________________

Billing # ____________________ **Phone #** _________________________**Fax #** ____________________________

Signature: ____

PLEASE FILL OUT THE FORM COMPLETELY AND CLEARLY TO FACILITATE PROCESSING