# REFERRAL FORM


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☐ **Paediatric Cardiac Consult/ Echo** ☐ **Fetal Cardiac Consult/ Echo** EDC: _______________
*(DD/MMY/YY)*

## Patient Information

Health Card Number: _______________________ Version code: ______ DOB: _________ Sex: M ☐ F ☐

Last Name: _______________________________ First Name: _______________________________________

Address___________________________________ City: _________________ Postal Code: _________________

Phone #:__________________________________ Cell #:________________ Other: ______________________

## Reason for Referral/Patient History

Please provide physical findings (i.e. birth weight, current weight, height, vital signs), medications, allergies, previous surgeries, family history:

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

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## Please attach relevant reports:

- ☐ Blood Work
- ☐ Holter report
- ☐ ECG
- ☐ Ultrasound (fetal patients)
- ☐ Chest x-ray
- ☐ Echo report
- ☐ Baby history questionnaire- under 2 months (refer to **FORMS** on our website)

## Please check the preferred location:

- ☐ 1371 Neilson Rd, Suite 409 **(Main Office)**
- ☐ North York General **(Tues: 8:00am-2:30pm)**
- ☐ Markham-Stouffville **(Thurs: 8:30am-4:00pm)**
- ☐ Ajax-Pickering **(Alt Wed: 1:00pm-4:00pm)**
- ☐ Lakeridge Health OSHAWA **(Alt Wed: 1:00pm-4:00pm**

## Referring Professional:

**Name:** _______________________ **Billing Number:** _______________

Professional Designation: _____________________________________

Address: ___________________________________________________

____________________________________________________________

Phone: ____________________ Fax: ___________________________

Copy reports to other Physicians: ______________________________

Phone#/Fax#:_______________________________________________

**Doctor's Signature:** _____________________________________________

**Please be advised patients will be contacted with an appointment by our office staff.**