



Rouge Valley Centenary
 2867 Ellesmere Road, 12th Level
 Toronto, ON, M1E 4B9

Phone: 416-281-7476 Fax: 416-281-7313

REFERRAL FORM

Please ensure all information is legible & complete to facilitate a prompt appointment

- Gastroenterology Clinic
- Regional Neonatal Follow Up Clinic
- Diabetic Education Clinic
- Nephrology Clinic
- Nutrition Counselling Centre
- Respiratory Syncytial Virus (RSV) Prophylaxis

- Haematology Clinic
- Rheumatology Clinic
- Neurology Clinic
- Constipation Clinic
- Asthma Community Care Centre
- Scoliosis Clinic

NON-URGENT: **URGENT:**

Patient Name _____

DOB _____ Male _____ Female _____

Address _____

Home Phone # (_____) _____ Can patient be called at this number ___Y ___N

Alternate Phone # (_____) _____ Language Spoken _____

Health Card # _____ Version Code _____

Name of Parent/Guardian/Contact Person _____ Phone#(_____) _____

Reason for Referral _____

Previous Relevant Medical Care for this Patient (recent test/results) _____

Family Doctor _____ **Physician #** _____

Phone # _____ **Fax#** _____

Address _____ **Postal Code:** _____

Referring Doctor _____ **Physician #** _____

(If not the same as Family Doctor)

Phone # _____ **Fax#** _____

Address _____ **Postal Code:** _____

Please Fax your completed form to the Galaxy 12 Clinic at 416-281-7313

For internal use only:

_____ Appointment Date and Time