



REQUISITION for CONSULTATIONS

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Urgent Consult: Yes No Reason: _____ Is patient in mental health treatment elsewhere? : Yes No

REFERRING PHYSICIAN:

Name: _____ OHIP Referral #: _____
Tel: () _____ Fax: () _____
Physician's Signature: _____ Date: (MM/DD/YR) ____/____/____

PATIENT INFORMATION:

Name: _____ D.O.B.: (MM/DD/YR) ____/____/____
HIN#: _____ Age of Patient: _____
Gender: Male Female School: _____ Grade: _____
Children's Aid Involvement: Yes No; Police Involvement: Yes No; Foster Care: Yes No; Adopted: Yes No
Legal Guardian: _____ Relationship to patient: _____
Tel: () _____ Work/Cell: () _____

REASON FOR REFERRAL:

MEDICAL HISTORY:

CURRENT MEDICATIONS:

ALLERGIES: NKDA _____

COMMENTS: (Feel free to attach additional info.)

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Please check if you would like us to send you more referral forms.