

# HOLLY MEDICAL CLINIC

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## REFERRAL FORM

REFERRAL DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

### PATIENT INFORMATION

(Affix Patient Label/Identification Here)

MRN: \_\_\_\_\_ HCN: \_\_\_\_\_

Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Please note: We accept patients by self-referral as well as referral by a Health Care Provider.

### ADDITIONAL PATIENT INFORMATION

Preferred name: \_\_\_\_\_ Medical Record Number (if known): \_\_\_\_\_

Gender: \_\_\_\_\_ Pronouns:  He/Him  She/Her  They/Them  Other: \_\_\_\_\_

Other insurance coverage (IFH, UHIP, etc.): \_\_\_\_\_  Self-pay

Language spoken: \_\_\_\_\_ Interpreter required:  Yes  No

Allergies: \_\_\_\_\_

### REFERRING PROVIDER INFORMATION

Name: \_\_\_\_\_ Billing #: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Signature: \_\_\_\_\_

Fax: \_\_\_\_\_

Referring Provider is not the Primary Care Provider

Primary Care Provider Name: \_\_\_\_\_

Primary Care Provider Telephone #: \_\_\_\_\_

### REASON FOR REFERRAL

Intrauterine Device (IUD) Insertion  Pap Test  Contraception Counselling

Intrauterine Device (IUD) Removal  Early Pregnancy Loss  Sexually Transmitted Infections (STIs) Testing/Treatment

Prenatal Care (hospital privileges for vaginal deliveries at Brampton Civic Hospital / William Osler Health System)

Other: \_\_\_\_\_

Diagnosis and/or chief complaint:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous management:

\_\_\_\_\_

\_\_\_\_\_

### CLINICAL INFORMATION / FINDINGS

#### Past and current medical history:

(Include cumulative patient profile, if available)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Please attach the following:

- Blood work (i.e. CBC, beta hCG)
- Ultrasound
- Test results (i.e. Pap Test, STI screening)
- Medical history

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