GENERAL SURGERY CONSULTATION REFERRAL FORM

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Brampton, Ontario
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REASON FOR REFERRAL (please specify):

- ☐ Breast Complaint (ie. benign, cancer, abscess)
- ☐ Gallbladder disease
- ☐ Perianal disease (hemorrhoids, fissures, abscess, fistula etc)
- ☐ Colonoscopy and Gastroscopy
- ☐ Lump and Bump Clinic (ie. Lipomas, sebaceous cysts)
- ☐ Ingrown Toenails
- ☐ Hernia (inguinal, incisional, umbilical)
- ☐ Other: _____

** PLEASE INCLUDE ALL RELEVANT MEDICAL REPORTS WITH THIS REFERRAL **

PATIENT INFORMATION (or label):

Name: _____
Last First

Date of Birth: _____ ☐ Male ☐Female
DD / MM / YYYY

Address: _____
Street # Street Name City Province Postal Code

Phone: _____ Alternate: _____

OHIP: _____
10 Digit # Version Code

REFERRED BY (Or stamp) :

Name: _____ Physician #: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

CONTACT INFORMATION:

Please FAX all referrals to 1 866 233 9346
For any questions please call my office at 905 792 6223

Thank you for the referral.