London & Region Outpatient Request for Consultation

Referral to Physician/Clinic:

_____

_____

Date of referral:

_____

Referring Physician Information

Name: _____

Phone #: _____

Fax #: _____

Billing #: _____

Patient Information

Name: _____

Date of Birth: _____

Health Card #: _____

Phone #: _____

Email: _____

Address: _____

_____

_____

Family Physician: _____

Referral Information

Details:

Investigations:

Urgency: ☐ < 72 hrs ☐ < 2 weeks ☐ 2 - 4 weeks ☐ > 4 weeks

Please notify patients directly with appointment details.

Referring Physician Signature: _____