Alexandra Hospital Ingersoll

29 Noxon Street
Ingersoll, Ontario N5C 1B8

REQUEST FOR CONSULTATION/REFERRAL

Date: (YYYY/MM/DD) _____

Referring Physician: Dr. _____ Consultant: Dr. _____

Referring Physician Billing #: _____

Consultation Service Requested: _____

Reason for Request:

_____
Referring Physician Signature

Office Use Only:

Appointment Date: _____ Time: _____

Appointment Details:

_____
_____
_____
_____
_____
_____
_____

Patient Notified by: _____

Date: _____ Time: _____