London Health Sciences Centre

PIN #:

NAME:

ADDRESS:

D.O.B. (YYYY/MM/DD):

HEALTH CARD # VERSION:

OUTPATIENT REFERRAL
FROM EMERGENCY DEPARTMENT (ED)
LONDON HEALTH SCIENCES CENTRE

Referral to Clinic and/or Physician: _____

Date of Referral: _____ / _____ / _____
YYYY MM DD

Urgency: ☐ less than 1 week ☐ 1 to 2 weeks ☐ within 4 weeks
☐ Elective

Reason for Referral: _____

Investigations in ED: _____

EMERGENCY DEPARTMENT
PHYSICIAN PRINTED NAME: _____ OHIP Billing #: _____

EMERGENCY DEPARTMENT
PHYSICIAN SIGNATURE: _____