Huron Perth Healthcare Alliance

Fax Referral Request

Referral to Physician and/or Clinic:____

Fax To #:____

Referred by: Dr.____

ED Site: ☐ Stratford ☐ St. Marys ☐ Clinton ☐ Seaforth

Phone:_________________________Ext.___________ Fax:______________________________________

Patient ED Visit Date: ___________________________ Total Pages:________________________________
(including this page)

Reason for Referral:

☐ The patient has been instructed to call your office for an appointment time

☐ The patient was informed that your office will contact him/her.

Referring MD Signature:________________________________ OHIP Billing #:______________________

IF THERE IS A PROBLEM WITH THIS TRANSMISSION PLEASE CALL THE SENDER

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