

EMERGENCY REFERRAL FORM

PATIENT INFORMATION

Surname: _____ Given Name: _____

Date of birth (YYYY/M/D): _____ Sex: M F Health card number: _____ Version Code: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Alternate: _____ Email: _____

WSIB WSIB Claim Number _____ Translator Required Language: _____

REFERRING PHYSICIAN/FACILITY INFORMATION

Physician Name: _____ Physician Number: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Fax: _____ Signature: _____

REASON FOR REFERRAL

Date of referral (YYYY/M/D): _____ Date of injury (YYYY/M/D): _____

Presenting complaint/nature of injury: _____

Supporting clinical documentation/investigation: (Please attach reports or access to online imaging eg. Pocket Health) _____

Relevant medical history: _____

Treatment to date: _____

Special needs/disabilities: _____

Dedicated fax number for URGENT/EMERGENT referrals: 519-646-6030

All urgent/emergent referrals will be triaged by the HULC consultant on call and the patients will be contacted directly for their appointment.

Referral deemed non-urgent. Please use normal referral form and fax number: 519-646-6049. <https://www.sjhc.london.on.ca/referral-forms#roth-mcfarlane-hand-and-upper-limb-centre-hulc>