Referral Letter for **Dr. Ifrah Hashi, MD, FRCPC**

General Pediatrician

Please Fax to:

519-474-0765

PHYSICIAN STAMP

Patient Name: .....

Parent/Guardian Name: .....

Address: .....

PHN: .....

DOB: .....

Home/Cell Number: .....

Email: .....

Referring Physicians Name: ..... Billing Number: .....

REASON FOR REFERRAL:

Urgency of Referral: 1 Week

Elective

Proudfoot Medical Clinic 524 Oxford St W #4 London, ON N6H 1T5 Phone: 519-473-5454
Fax: 519-474-0765