

# Referral/Consultation Request C Difficile

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Infectious Diseases Care Program

St. Joseph's Hospital

268 Grosvenor Street

London, ON N6A 4V2

Phone: 519 646-6311 Fax: 519 646-6328

## Patient information:

Surname:

Given Name:

Date of birth (YYYY/M/D):

Sex: M F

Health card number:

VC:

Address:

City:

Postal Code:

Home Phone:

Translator Required/Language:

**PATIENT EMAIL ADDRESS:**

**\*\* (First appointment done via video) \*\***

## REFERRING PHYSICIAN/FACILITY INFORMATION

Physician Name:

Physician Number:

Phone:

Fax:

Signature:

## Reason for referral:

Supporting clinical documentation/investigation: (Please attach ALL C-Difficile LAB reports, recent bloodwork, if available Stool C Difficile toxin reports, any x-ray imaging and patient past health history):

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## Medications:

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## Previous Treatments:

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