Referral/Consultation Request C Difficile

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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:

_____
_____
_____
_____

Previous Treatments:

_____
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