REFERRAL FORM

Patient Profile

First Name Last Name

Date of Birth Health Card Number

Contact Number : Address :

Referring Physician Profile

Name CPSO Number :

Location : MoH Billing Number :

Phone : Fax :

Please indicate as applicable	FHO	FHG	FHT	FFS	Specialist	Hospital / ER

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Reason for Referral *(Please provide detail as much as possible)*

Please indicate as applicable

Headache | Neck Pain | Back pain | Hip pain | Knee pain | Shoulder Pain

Others:

Please send following documents relevant to the referral if you have any:

1. Relevant Diagnostic imaging (X-Rays, USS, MRI, CT scan)
2. Previous consults with any other relevant specialist
3. List of active medications

Please send your referral with the applicable documents via fax for your intended location of service as below:

IPC-Chatham	IPC -Cambridge
547-Queen Street, Chatham, Ontario, N7M 2J4 Ph: 519-360-9000 Fax: 519-360-9006	Unit 102-Franklin Blvd, Cambridge, Ontario, N1R 7J2 Phone:519-620-0606 Fax: 519-620-9339