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**CHILDBIRTH & CHILDREN'S CENTRE
 PHYSICIAN REFERRAL**

To:	
Specialty:	
Date:	Fax: ()

Patient Name	Date of Birth: (DD/MM/YY)
Address:	Health Card #
Parents <i>Last</i> <i>First</i>	Home Phone: ()
Mother's Name:	Work Phone: ()
Father's Name:	Home Phone: ()
	Work Phone: ()
Appointment Date: (DD/MM/YY) _____	
Reason for Referral	
Other Significant Medical History	
Medication	

Referring Physician Name	Referring Physician Signature	Physician for follow-up
Physician number: ()		

