

NOTE: Incomplete and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

**COMMUNITY MEDICINE CLINIC
HOSPITAL TO HOME PROGRAM REFERRAL**

Markham Site Booking Line: **(905) 472-7534**

Please Fax To: **(905) 472-7535**

Patient Name: _____ <small>Last First</small>
Date of Birth: _____ Sex: F M <small>Day Month Year</small>
Health Card # _____ Version Code: _____
Address: _____ Postal Code: _____
Telephone # (Best Daytime): _____
Alternate #: _____
Family Physician: _____

Date	Referring MD	Signature
Billing #	Telephone	Fax
Address	City	Postal Code
Additional Reports to:		
Spoken Language if other than English. Please bring translator to the appointment if required.		
Request for: <input type="checkbox"/> Community Medicine Clinic <input checked="" type="checkbox"/> Hospital to Home <input type="checkbox"/> Emergent (within 48 hours) <input type="checkbox"/> Urgent (within 1 week) <input type="checkbox"/> Elective (within 1 month)		
Reason for Referral		
Past Medical History		
Current Medications		
Other		
* Please attach any recent blood work or pertinent test results *		

