MARKHAM STOUFFVILLE HOSPITAL CORPORATION

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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 *Last* *First*	Home Phone: ( )
Mother's Name:	Work Phone: ( )
	Home Phone: ( )
Father's Name:	Work Phone: ( )

Appointment Date: *(DD/MM/YY)* _____

Reason for Referral

Other Significant Medical History

Medication

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