NOTE: Incomplete and / or unsigned requistions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

COMMUNITY MEDICINE CLINIC
HOSPITAL TO HOME PROGRAM REFERRAL
Eastern York Region

Markham Site Booking Line: **(905) 472-7373 x6928**
Please Fax To: **(905) 472-7535**

Patient Name: _____
Last First

Date of Birth: _____
Day Month Year

Sex: F M

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 Languange if other than English. **Please bring translator to the appointment if required.**

Request for: ☐ Community Medicine Clinic ☐ Hospital to Home
☐ Emergent (within 48 hours) ☐ Urgent (within 1 week) ☐ Elective (within 1 month)

Reason for Referral

Past Medical History

Current Medications

Other

*** Please attach any recent blood work or pertinent test results ***

*** Please note: Patients outside of Eastern York Region Sub Region must be seen in CMC for initial evaluation ***