MARKHAM STOUFFVILLE HOSPITAL CORPORATION

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name (Last, First): _____

Telephone # (Best Daytime): _____

Date of Birth (DD/MM/YYYY): _____ Sex: F M

Health Card #: _____ Version Code: _____

PAIN & SYMPTOM MANAGEMENT REFERRAL

Ambulatory Clinic 2 - Medical Day / Chemo

Fax: 905-472-7560

Phone: 905-472-7373 ext. 7068

Referring Physician:(print) _____ Signature: _____ Date: _____

Urgency of Referral: ☐ 24hrs ☐ 1 Wk. ☐ 4 - 6 Wk.

Chief Complaint:

Clinical History Relevant to Chief Complaint:

Allergies:

Significant Medical History Related to Chieft Complaint:

Current Medications

Referrals ☐ SW ☐ Dietician