

**Referral for Consultation**

Patient's name \_\_\_\_\_

Date of birth \_\_\_\_\_ Male  Female

Referring doctor \_\_\_\_\_ Phone \_\_\_\_\_

Indication for the consult: \_\_\_\_\_

**Please attach a copy of your clinical notes dealing with the reason for this referral. Also include updated demographics.**

**\*\*Please fax to 574-0330\*\***



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