NOTE: Incomplete and / or unsigned requistions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Oak Valley Health

Community Health Clinic Referral

Please Fax To: **905-591-5544**

Telephone: **905-591-5454**

Hospital MRN #: _____

Patient Name: _____
Last First

Date of Birth: _____ Sex: F M
Day Month Year

Health Card # _____ Version Code: _____

☐ WSIB Claim #: _____ ☐ Non OHIP, Self-pay or Refugee

Telephone # (Best Daytime): _____

Alternate #: _____

Date	**Referring MD/NP**	**Signature**	**Telephone**
CPSO #	**Billing #**	**Address**	**Fax**

Additional Reports to:

Preferred Language	Name & number of for interpreter to help schedule appointment, if available

Does patient have a primary provider? ☐ Yes ☐ No If yes: _____

Referral Request From:

- ☐ Transgender Affirming Clinic
- ☐ Primary Care walkin, FHO, FHT
- ☐ CAMH
- ☐ EMS
- ☐ Public Health
- ☐ Newborn Clinic
- ☐ GIM
- ☐ Adult Diabetes
- ☐ ED
- ☐ Other: _____
- ☐ OVH Inpatient
- ☐ Surgery
- ☐ Paediatrics
- ☐ Rapid Access Clinic for Low Back Pain

Reason for Referral:

_____

_____

Clinical Information:

_____

_____

Current Medication: _____

_____

Completed Tests / Procedures: ☐ X-ray ☐ MRI ☐ CT ☐ LAB

☐ Others: _____

Please attach any supporting documents