Priority Health General Internal Medicine Clinic
100-1690 Dersan Street, Pickering, ON L1V 2P8
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Please fax the completed form + additional information to 1-855-493-3223 - Thank you for your referral!

INTERNAL MEDICINE REFERRAL FORM

Date of Referral: ___________________________________

☐ Urgent ☐ Semi-urgent ☐ Routine

Referring Provider:
OHIP Billing #:
Office Phone:
Fax:
Address:

Family Doctor:
OHIP Billing #:
Office Phone:
Fax:
Address:

Patient First and Last Name:
DOB (D-M-Y):
Health Card #:
Phone:
Alternate Phone:
Email:
Mailing Address:

Please attach patient's medical profile and other relevant bloodwork and imaging

MAIN REASON FOR REFERRAL:
If applicable, select all that apply from below

☐ Hypertension
☐ Syncope/Presyncope
☐ Dyspnea
☐ Venous Thromboembolic Disease
☐ Coronary Artery Disease (CAD)
☐ Arrhythmias
☐ Anemia
☐ Thrombocytopenia
☐ Iron Infusions
☐ Bleeding/Clotting Disorders
☐ Abnormal Bloodwork (e.g. High ferritin, High ALP, etc.)
☐ Thyroid Disorders
☐ Hyponatremia
☐ Fatigue
☐ Weight Loss
☐ Night Sweats
☐ Headaches
☐ Other ____

____

DETAILS: