VICTORIA MEDICAL GROUP
Unit 201, 1252 Lawrence Avenue East, North York, ON M3A 1C3
Tel: 416-609-1100 | Fax: 416-335-0036

SPECIALIST REFERRAL FORM

PATIENT INFORMATION

Patient Name: _____	**Date of Birth (YYYY/MM/DD):** _____
Health Card No.: _____	**Version Code:** _____
Phone: _____	**Email:** _____

REQUESTED SPECIALTY / SERVICE (Please check one or more)

☐ Cardiology Consultation	☐ Psychiatry Consultation	☐ Rheumatology
☐ Dermatology	☐ Psychotherapy	☐ Joint Injection
☐ Internal Medicine	☐ Geriatrics	☐ Weight Management
☐ Diabetes Education & Counselling	☐ Other: _____	

CLINICAL INFORMATION

Reason for Referral / Clinical Question:

Relevant History, Symptoms and Examination Findings:

Current Medications / Allergies:

Relevant Investigations / Results:

Priority: ☐ Routine ☐ Urgent ☐ Semi-Urgent	Others (please specify):
Attachments: ☐ Labs ☐ Imaging ☐ Consult Notes ☐ Other	

REFERRING PROVIDER INFORMATION

Referring Physician:	**Billing / Provider #:**
Physician Signature:	**Referral Date:**
Clinic Fax:	**Clinic Phone:**
Clinic Address/Stamp:	

Please fax the completed referral and relevant clinical documents to 416-335-0036. We will call to book.

Thank you for your referrals!