Physician Referral Form

Northern Ontario Surgical Centre

Fax: 705.523.4720

Referring Physician: ______________________________ **Referring Physician #:** __________________

Physician Address: ____

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Physician Phone #: _______________________________

Patient's Name: _______________________________ **Gender:** _________

Date of Birth: d _________m_________y__________ **HCN:** ________________________ ____

Address: ________________________________ **Phone #:** _________________________

(include mailing address if req'd) ________________________________

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Reason for Referral:

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Medical History:

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Referring Physician Signature: ______________________________ **Date:** ________________________

Please complete the above information and fax along with the referral letter and relevant reports to (705) 523-4720

205 Douglas, Sudbury, ON P3E 1E9 Tel : (705) 674.4300 Toll Free : 1.855.674.4300 Fax : (705) 523.4720