APEX MEDICAL CENTRE

REFERRAL FORM

2-1120 Kingston Rd, Scarborough, ON
Phone: 416-690-7111
Fax: 416-690-4111

Referral Date (DD/MM/YY): **Urgency:** ○ Routine ○ Semi-urgent ○ Urgent

PATIENT INFORMATION

Full Name:
HIN/UCI:
Address:
D.O.B: Gender:
Tel No.: Cell No.:
E-mail:

REFERRING PHYSICIAN

Name:
Billing No.:
Address:
Tel No.:
Fax No.:
MD Signature:

CARDIOLOGY SERVICES: ☐ With Consult

☐ ECG ☐ Echocardiogram ☐ 48hr Holter ☐ 72hr Holter ☐ 2 week Holter

INDICATION:

☐ Chest pain ☐ Edema ☐ HTN ☐ Arrhythmia
☐ Dyspnea ☐ CHF ☐ Dizziness ☐ Valve Disease
☐ Palpitations ☐ CAD ☐ Murmur ☐ Abnormal ECG
☐ Syncope
☐ Other: _____

JOINT & SOFT-TISSUE INJECTION CLINIC CONSULTATION

Side: ☐ Left ☐ Right ☐ Bilateral

☐ Knee – knee OA
☐ Subacromial space – RC tendinopathy, subacromial bursitis
☐ Glenohumeral joint – adhesive capsulitis, GH OA
☐ AC joint – AC joint OA
☐ Carpal tunnel – carpal tunnel syndrome
☐ Elbow – lateral / medial epicondylitis
☐ Greater trochanter – GTPS, trochanteric bursitis
☐ Trigger finger / thumb – tendon sheath
☐ De Quervain tenosynovitis – 1st dorsal compartment
☐ Thumb CMC joint – 1st CMC OA
☐ Other: _____

OTHER SERVICES:

☐ Iron Infusion Assessment ☐ Internal Medicine Consultation ☐ ADHD Assessment

REASON FOR REFERRAL & ADDITIONAL HISTORY: (Please attach medical profile and recent investigations with referral)