HÔPITAL Glengarry Memorial HOSPITAL

HEMATOLOGY & THROMBOEMBOLISM CLINIC REFERRAL FORM

Last Name	**First Name**
Date of Birth	**Health Insurance Card No.**
Date of Request (yyyy-mm-dd)	**Address**
Telephone 1	**Telephone 2**

Only referrals containing a **detailed medical history, medication list, blood work, diagnostic imaging reports and this completed form will be accepted**. Referrals are accepted for patients aged 16 years and older.

FAX the completed referral package to Community Wide Scheduling **(613) 525-0147**

PHYSICIAN INFORMATION

Referring Provider (print):	Billing No.:
Address:	Phone:
	Fax:
Referring Provider Signature:	
Primary Care Provider (if different from above):	Billing No.:
Address:	Phone:
	Fax:

REASON FOR REFERRAL

Please provide pertinent clinical summary:

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Urgency: ☐Urgent ☐Elective ☐ Include test results related to the reason for consultation

OFFICE USE ONLY

Date Received:	Appointment Date & Time:

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