Please use this fax cover sheet together with the Outpatient Neuro-Palliative Referral Form.

- Be sure to fill in your sender Name, Phone, and Fax Number below.
- Please ensure you have included the following with your referral:
  - Physician/NP Signature
  - Copies of consultations
  - Copies of diagnostics
  - Diagnosis and reason for the outpatient Neuro-Palliative Referral

Fax

Date:

To: Outpatient Ambulatory Clinics, Unity Health Toronto - Providence Healthcare

Fax: 416-285-3764

From:

Phone:

Re: Referral to Outpatient Neuro-Palliative Care Clinic **Pages** (including cover) **:**

Please see the attached referral to the Outpatient Neuro-Palliative Care Clinic.

If you experience problems receiving this fax, please call the sender.

PROVIDENCE
UNITY HEALTH TORONTO

(Addressograph

Dr. Usha Ramanathan, MD FRCPC
Neuro-Palliative Care Clinic
B Wing, 1st Floor, 3276 St. Clair Avenue East, Toronto, M1L 1W1
Tel: 416-285-3619, Fax: 416-285-3764

Referral for Consultation

* STRICTLY CONFIDENTIAL*

Client Information

Surname: _____ First Name: _____ ☐ M ☐ F

Health Card: _____ DOB: _____ Marital Status: _____
VC D M Y

Allergies:_____ ☐ Client aware of referral

Address: _____

Home Phone: ( )_____ Work Phone: ( )_____Languages Spoken: _____

Contact Person: _____ Phone: ( )_____Relationship to Client: _____

Referring Physician

Name: _____ Phone: ( )_____

Fax: ( )_____ Physician #_____

Address:_____

Ambulatory Status: ☐ Independent ☐ Wheelchair ☐ Assistive Devices: _____

Reason for Referral:

_____

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For office use only

Date Received: _____ Appointment Date/Time: _____