

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.

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(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:
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:

Reason for Referral:
[Multiple horizontal lines for text entry]

For office use only
Date Received: Appointment Date/Time: