Neurovascular Referral
St. Michael's Hospital

30 Bond Street,
Toronto, ON M5B 1W8
Tel: 416-864-5131

7 4 2 6 0

ST. MICHAEL'S
UNITY HEALTH TORONTO

Please Fax Completed Referral To :

Fax: 416-864-5716

REFERRING HEALTH CARE PROVIDER

(Please print- last name, first name)

Name:_____

MOH Billing# _____

Address: _____

_____

Postal Code:_____

Phone: _____

Fax: _____

Date of referral: _____

FAMILY DOCTOR (***if different from above***)

Name: _____

Location: _____

_____

PATIENT INFORMATION OR AFFIX LABEL WITH ALL INFORMATION

SMH MED. RECORD#	LAST NAME	FIRST NAME

ADDRESS

POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE

DATE OF BIRTH (MONTH / DAY / YEAR)	AGE	SEX

ONTARIO HEALTH CARD #	VERSION CODE	OTHER INSURANCE

SPECIAL NEEDS: ☐ Interpreter Required

Language Spoken _____Other:_____

Reason for referral:

Current symptoms:

Neuroimaging findings: