St. Michael's

Inspired Care.
Inspiring Science.

Patient ID

Fax consultation request to: (416) 867-3681
Telephone: (416) 867-7460 ext. 8114
Email: stoneprevention@smh.ca

The Kidney Stone Prevention Clinic REFERRAL

Patient Information

Last Name: ______________________ First Name: ______________________

Tel. (Home): ____________________ Tel. (Business): ____________________

Address: Street ______________________________________ Apt No. __________

City __________ Province ______________ Postal Code: ______________

Date of Birth (D.M.Y) ______________ ☐ Female ☐ Male

Health Card No. ______________ Version Code: ______________

Family MD: ______________________________________

Please indicate if applicable:

Stone Analysis: Unknown ☐ COD ☐ COM ☐ COD & COM ☐ Cystine ☐ UA ☐ UA & CO ☐ CaP04 ☐

CO & CaP04 ☐ Others please specify ______________________________

Stone History: First ☐ Recurrent ☐ ESWL: Y / N Surgery: Y / N

Current Medications:	**Other/History:**

Additional Information: ______________________________________

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Referring MD: ______________________

Billing Number: ______________________

Phone #: ______________________

Fax #: ______________________

Date: ______________________

Please fax the most recent imaging (KUB x-ray, renal ultrasound, abdominal CT) and STONE ANALYSIS with 24 hour metabolic workup to **(416) 867–3681.**

Form No. 73000 Dev. Feb.16/2016