ST. MICHAEL'S
UNITY HEALTH TORONTO

HEAD INJURY CLINIC REFERRAL FORM

3rd Floor Donnelly Wing South

Fax: 416-864-6098 / Telephone: 416-864-5520

INCOMPLETE REFERRAL WILL BE RETURNED.

☐ 1st AVAILABLE
☐ Dr. Alice Kam ☐ Dr. Alan Tam ☐ Dr. Chantal Vaidyanath

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Last Name:	
First Name:	
DOB: YYYY-MM-DD	Gender:
Health Card #:	Version Code:
Phone #:	
Alternate Phone #:	
Mailing Address: No., Street or RR, Apt., City, Province, Postal Code	

ADDITIONAL PATIENT INFORMATION

Email Address:	Candidate for Video Appointment: ◯ Yes ◯ No	
Patient consent to: ☐ phone call ☐ leave voice message ☐ email (attached consent form must be signed)		
Language Spoken:	Interpreter Required: ◯ Yes ◯ No	
Alternate Contact: Full name (& relationship)	Phone #:	
☐ Self-pay ☐ OHIP ☐ Private Insurance ☐ MVC ☐ IFH ☐ WSIB Claim#:		☐ Others:
Primary Care Provider: (if different from referring)	Phone #:	Fax #:
Address:		

REASON FOR REFERRAL

Date of Injury / Event: YYYY-MM-DD

Please provide details of injury, symptoms, concerns, etc.

PLEASE INCLUDE WITH THIS FORM

☐ Consult notes and discharge summary
☐ Medical imaging reports
☐ Laboratory reports
☐ Medication list

☐ Internal referral only: Required information available on EMR.

☐ Others:

REFERRING PROVIDER INFORMATION

Full Name: ◯ MD / ◯ NP	CPSO/CNO #:	**Billing #:** REQUIRED
Office Address:	Phone #:	Fax #:
	Date: YYYY-MM-DD	**SIGNATURE:** REQUIRED

FOR HIC OFFICE USE ONLY

Triaged by: Date: YYYY-MM-DD	NOTE:
Appointment booked: YYYY-MM-DD With Dr.:	

Reset Form | Print | Save

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PATIENT CONSENT TO COMMUNICATE BY EMAIL

I understand and accept that there are significant risks associated with email communications, including these:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails passing through their systems.
- Emails can be intercepted, forwarded, circulated, stored or even changed without the knowledge or permission of either the sender or recipient.
- Copies of an email may continue to exist, even after reasonable efforts to delete the email have been made.
- Someone other than me may send an email in my name, and this impersonation may not be detected by the recipient.
- Email may carry computer viruses that may damage computer data or software or disclose my information against my wishes.
- Email may be accidentally sent to an unintended recipient, or to many such recipients.
- Email may be disclosed to third parties or to the public, regardless of the intentions of the receiver or sender.

I understand and agree that if the Hospital engages in email communication with me:

- The Hospital or one or more of my Hospital email correspondents may decide to stop doing so, at any time, for their own reasons.
- **I must not use email for medical emergencies or other time-sensitive matters. If I need immediate assistance or have a condition that appears serious or worsens rapidly, I must not rely on email. Instead, I should take other measures as appropriate, which may include seeking emergency services.**
- The Hospital may require that I follow additional rules for the use of email communication that it may set at any time. In addition, areas within the hospital and/or individuals working on behalf of the Hospital may require that I follow additional rules that they may set at any time.
- The Hospital may use or disclose my email and/or the information in it to people other than the intended recipient, for a variety of purposes—for example, to update my health records, and to permit others to assist in my care or in record-keeping.
- The Hospital cannot guarantee that any particular email will be read and responded to within any particular time period.
- Neither the Hospital nor those communicating on its behalf will be liable for any harmful consequence to me that may arise from the use of email.

- If I wish to withdraw my consent to communicate by email, I may do so at any time, but I must do so in writing and ensure all relevant email correspondents receive a copy of my withdrawal notice.
- If my email address changes, I shall promptly inform my email correspondents. • If I feel there is an undue delay in response to an email I send, it is my responsibility to follow up.

My email address is:
(please print) _____

Patient Name:
(please print) _____

Patient Birthday:
(yyyy/mm/dd) _____ MRN: _____

Signature of Patient
(or Substitute Decision-Maker) _____

Name of Substitute Decision-Maker
(if applicable)
(please print) _____

Date: _____
yyyy/mm/dd

CHECK HERE TO CONFIRM

WITHDRAWAL OF ABOVE CONSENT ON _____
yyyy/mm/dd

WITHDRAWAL REQUESTED BY: _____