ST. MICHAEL'S
UNITY HEALTH TORONTO

7 4 5 3 2

Head Injury Clinic
3rd floor Donnelly Wing South
Tel: 416-864-5520
Fax: 416-864-6098

Patient information:

Last name: _____

First name: _____

DOB: _____

Gender: _____

MRN/OHIP: _____

Phone: _____

Address: _____

_____

Patient's Email: _____

☐ **Interpreter: Language** _____

HEAD INJURY CLINIC REFERRAL

An incomplete referral form will not be processed and will be returned to the referring provider.

Patient to be seen by (please select):	**Referring physician or nurse practitioner information:**
Physiatrists: ☐ Dr. Meiqi Guo ☐ Dr. Cheryl Masanic ☐ Dr. Alan Tam ☐ Dr. Chantal Vaidyanath ☐ **OR First Available Physiatrist**	Name: _____ (☐ MD / ☐ NP) (Print full name) (Please select) CPSO#:_____ Billing#: _____ Location of Practice: _____ _____ Tel#:_____ Fax#:_____ Signature: _____ Date of referral: _____

Reason for Referral:

Attachments (relevant):

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

☐ **ONLY check if attachments are available at SMH Soarian Medical Record**

FOR HEAD INJURY CLINIC USE ONLY!
NOTE: