SCAD Referral Form

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ST. MICHAEL'S
UNITY HEALTH TORONTO

PATIENT DEMOGRAPHICS:			
PATIENT'S FIRST NAME:	LAST NAME:	DATE OF BIRTH: DD/MM/YYYY	
ADDRESS:	UNIT #:	CITY:	POSTAL CODE:
OHIP:		VC:	
HOME #:	CELL #:	OTHER:	
EMAIL:		CONSENT TO CONTACT BY EMAIL: YES / NO	
CONTACT (NEXT OF KIN):		TEL #:	
FAMILY PHYSICIAN:			

REFERRING PHYSICIAN		
FIRST NAME:	LAST NAME:	OHIP BILLING #:
ADDRESS:	CITY:	POSTAL CODE:
PHONE #:	FAX #:	EMAIL:
SIGNATURE:		

REASON FOR REFERRAL:

_____
_____
_____
_____
_____

PREVIOUS PROCEDURES (PLEASE INCLUDE DATES/HOSPITAL)		
☐ ANGIO/ PCI DATE: _____	☐ CT ABDOMEN DATE: _____	☐ CT HEAD DATE: _____

***PLEASE INCLUDE THE FOLLOWING WITH THE REFERRAL:**
CD images – Angio or PCI (current and prior if applicable)
Angiogram report/Discharge summary
Diagnostic Imaging Reports (Echo, MIBI, CT scans etc) if applicable
*** PATIENTS WILL NOT BE BOOKED WITHOUT THE ABOVE INFORMATION***

CLINIC USE ONLY

DATE REFERRAL RECEIVED:	APPOINTMENT DATE:_____ TIME:_____