SURREY PLACE

Referral for Medical Services Consultation

Patient Name:	**OHIP & Version Code:**
Date of Birth:	**Surrey Place ID:**
Contact Info:	

☐ **Family Medicine Consultation** ☐ **Developmental Pediatrics Consultation**
☐ **Adult Psychiatry Consultation** ☐ **Geriatric Psychiatry Consultation (Plus 45 Clinic)**
☐ **Children's Psychiatry Consultation**
☐ **Other**_____

Please ensure all fields are filled out and all necessary information is included to complete this referral.

Reason for referral:

Diagnoses, health concerns and relevant medical history:

Current medications:
☐ *Medication list attached.*

Please list and/or attach any relevant investigations/reports:

Referral Source/Contact Person (if different from the Referring Physician/NP):

Name: **Profession:** **Program:**
Phone: **Fax:** **Email:**

Is patient/family aware of this referral? ☐ Yes ☐ No

Referring Physician/NP's Information or Stamp:

Name: **OHIP Billing:**
Phone: **Fax:**
Address:
Signature:

Please fax completed referral to Surrey Place Medical Services fax number 416 929 8199