URGENT MEDICAL CLINIC REFERRAL FORM

FAX TO 64020

- **Please refer <u>only</u> patients with *significant* or *new* medical problems requiring *urgent* assessment**
- **Lack of family physician is <u>not</u> criterion for referral**

Last Name:_____ First Name:_____

J#:_____ Date of Birth:_____

Ref Phys:_____ Fam Phys._____

Reason for referral:

_____

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Please attach the Urgent Care Record as well as any relevant investigations not available on PowerChart.

Patient will be contacted by phone or mail with their appointment.

If patient has not received an appointment one week after referral was made, they may call 519-646-6100 x64674 to check on the status of their referral.