London & Region Medical Referrals

Londonreferral.com

Referral to Physician and/or Clinic:____

Date of Referral:____________________________ Urgency: ☐ Less than 1 week ☐ 1-2 Weeks

Referred by:________________________________ ☐ Within 4 weeks ☐ Elective

Phone:____ Fax:_______________________________________

Address:____

Reason for Referral:

Please notify patients directly with appointment details and directions.

Referring MD Signature:_________________________________ OHIP Billing #:______________________

A project by Dr. Adam Fogel & Dr. Munsif Bhimani