

REFERRAL FORM

2 Champagne Drive (Champagne Centre), Toronto, ON M3J 0K2

Tel: 416-222-6160

www.polyclinic.ca

hr@polyclinic.ca

PATIENT INFORMATION

Name: _____
Tel: _____
Address: _____

M D Y
DOB _____ / _____ / _____
HC# _____ VC _____
Referring Physician: _____
Provider #: _____

PLEASE CHECK ALL CONSULTATION AND/OR DIAGNOSTIC SERVICES REQUESTED

SPECIALTY DEPARTMENT UNIT B17 TEL: 416-222-6160 Ext. 268, 269, 277, 278 FAX: 416-645-1978

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Nerve Conduction Study ext. 278 | <input type="checkbox"/> Respiriology |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Gynecology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Audio Testing | <input type="checkbox"/> Hepatology | <input type="checkbox"/> Orthopedic Surgery | |
| <input type="checkbox"/> VNG | <input type="checkbox"/> Fibroscan | <input type="checkbox"/> Plastic Surgery | |

NEUROLOGY DEPARTMENT UNIT B10 TEL: 416-222-6160 EXT. 255, FAX: 416-645-1979

- ☐ Neurology Consult

PDS CARDIAC IMAGING UNIT B10, TEL: 416-222-6160 EXT.243, FAX: 416-386-1023

- | | | | |
|---|---|--|--|
| <u>Cardiology</u> | <u>Cardiac Diagnostic Testing</u> | <u>Indications</u> | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cardiology Consult | <input type="checkbox"/> ECG | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> High Cholesterol |
| | <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> History of MI / Stroke | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> Stress Test | <input type="checkbox"/> Angina / Ischemic Heart Disease | <input type="checkbox"/> Family history of heart disease |
| | <input type="checkbox"/> Stress Echocardiogram | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Atrial Fibrillation / Arrhythmias |
| | <u>Holter Monitor Testing</u> | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Abnormal ECG |
| | <input type="checkbox"/> 24 hrs <input type="checkbox"/> 48 hrs <input type="checkbox"/> 72 hrs | <input type="checkbox"/> Dizziness / Lightheadedness | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> 7 day <input type="checkbox"/> 14 day <input type="checkbox"/> ABPM | <input type="checkbox"/> Syncope | |

NORTH YORK ENDOSCOPY CENTRE UNIT B19 TEL: 416-645-5145 FAX: 416-645-1401

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> General Surgery Consult | <input type="checkbox"/> Gastroscopy |
| <input type="checkbox"/> Gastroenterology Consult | <input type="checkbox"/> Colonoscopy |

NORTH YORK PULMONARY FUNCTION CENTER UNIT B21 TEL: 416-636-6664 FAX: 416-636-8999

- | | | |
|--|---|---|
| <input type="checkbox"/> Respiratory Consult | <input type="checkbox"/> Spirometry | <input type="checkbox"/> Methacholine Challenge Testing |
| <input type="checkbox"/> Complete PFT | <input type="checkbox"/> Resting Oximetry | <input type="checkbox"/> Pre/Post Bronchodilator |

NORTH YORK SLEEP AND DIAGNOSTIC CENTRE UNIT B15 TEL: 416-642-4232 FAX: 416-642-4234

- | | | |
|---|--|---|
| <input type="checkbox"/> Consultation and Sleep Study | <input type="checkbox"/> Consultation Only | <input type="checkbox"/> Sleep Study Only |
|---|--|---|

PDS DIAGNOSTIC IMAGING UNIT B23 TEL: 416-741-2766 FAX: 416-741-6015

- | | | |
|--|--|--|
| <input type="checkbox"/> X-Ray _____ | <input type="checkbox"/> Ultrasound _____ | <input type="checkbox"/> Biopsy _____ |
| <input type="checkbox"/> BMD _____ | <input type="checkbox"/> Vascular Ultrasound _____ | <input type="checkbox"/> Injection _____ |
| <input type="checkbox"/> Mammography _____ | | <input type="checkbox"/> Other _____ |

Name of Physician / NP: _____ Location: _____

Reason for Referral (Required): _____

Signature of Referring Physician / NP: _____ Date: _____