

REFERRAL LETTER – NON EMERGENCY

AFFIX LABEL HERE

*DATE: _____ * DOB: _____ (DD/MM/YYYY)

**FAX COMPLETED REFERRALS TO
(905) 897-7780**

*LAST NAME: _____ *FIRST NAME: _____

How Did You Find Out About Us?

*PHONE #: _____ EMAIL: _____

Google Fax Patients Other

TO:

INTERNAL MEDICINE & SUB SPECIALTIES	
<input type="checkbox"/> GENERAL INTERNAL MEDICINE	<small>Urgent Same Day Referral by Walk-In</small>
<input type="checkbox"/> ALLERGY CLINIC	
<input type="checkbox"/> CARDIOLOGY CLINIC	
<input type="checkbox"/> ONCOLOGIST (CANCER)	
<input type="checkbox"/> GASTROENTEROLOGY CLINIC	
<input type="checkbox"/> TRAVEL MEDICINE	
<input type="checkbox"/> INFECTIOUS DISEASES	
<input type="checkbox"/> NEPHROLOGY CLINIC	
<input type="checkbox"/> NEUROLOGY CLINIC	
<input type="checkbox"/> RESPIROLOGY CLINIC	
<input type="checkbox"/> RHEUMATOLOGY/PAIN CLINIC	
<input type="checkbox"/> ENDOCRINE CLINIC	
<input type="checkbox"/> HEMATOLOGY CLINIC	

<input type="checkbox"/> EYE CLINIC	<small>Minor eye problems/Refracting</small>
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PEDIATRICS & SUB SPECIALTIES	
<input type="checkbox"/> GENERAL PEDIATRICIAN	<small>(urgent same day referral by walk-in)</small>
<input type="checkbox"/> PEDIATRIC	<ul style="list-style-type: none"> • RESPIROLOGIST • ALLERGY CLINIC • CARDIOLOGIST • DERM CLINIC • NEUROLOGY CLINIC
WOMEN'S CLINIC & SUB SPECIALTIES	
<input type="checkbox"/> GYNECOLOGIST	<small>Hormone Clinic-BCP/MAP Irregular Periods Infect Disease Clinic-VD/STD PAP-test/IUD/Colposcopy</small>
<input type="checkbox"/> FETAL & MATERNAL CARDIOLOGIST	
SURGICAL CLINICS & SUB SPECIALTIES	
<input type="checkbox"/> GENERAL SURGEON	
<input type="checkbox"/> ORTHOPEDIC Surg	<input type="checkbox"/> ENT Surg
<input type="checkbox"/> PLASTIC Surg	<input type="checkbox"/> FOOT Surg <input type="checkbox"/> CHEST Surg
<small>Skin cancer clinic</small>	
<input type="checkbox"/> UROLOGY CLINIC	<small>Prostate, ED, Urological issues etc.</small>

Reason for referral:

Patient or representative requested another opinion:

Physician request because:

*PHYSICIAN'S SIGNATURE: _____

*PHYSICIAN'S NAME: _____

[Non- emergency cases only. For Emerg. Care physician agrees to personally

* REFERRING PHYSICIAN OHIP #: _____

Refer them to ER directly]

Fax #: _____

Simply have the patient call us at 905-897-8928 or fax this referral to 905-897-7780 with the signed referral for an appointment. Some Specialist appointments can be booked online! Check for online booking availability by visiting www.WalkinWalkin.com/appt For appointments, information regarding specialty clinics or any problems with this referral, please contact the clinic. 21 Queensway West, Mississauga, Ontario, L5B1B6 | For more information, visit www.RapidAccessToMedicalSpecialists.ca