2 Champagne Drive, Unit E2
Toronto, ON M3J 0K2

REFERRAL FORM

PATIENT INFORMATION

Full Name: _____ Gender: ☐ M ☐ F ☐ Other DOB: _____
First *Last* *DD/MM/YYY*

OHIP No. with Version Code: _____ Email Address: _____

Main Phone Number: _____ Secondary Phone Number: _____

Address: _____ City: _____ Postal Code: _____

Primary Care Physician: _____ Current MRP for Wound Care: _____

PLEASE INDICATE THE REFERRAL TYPE: ☐ HBOT ☐ Wound Care & HBOT

REASON FOR REFERRAL

- ☐ Chronic/Problem Wound
- ☐ Diabetic Foot Ulcer
- ☐ Non-healing Surgical Wounds
- ☐ Refractory Osteomyelitis
- ☐ Compromised Flaps/Grafts
- ☐ Sudden Sensorineural Hearing Loss
- ☐ Crush Injury/Compartment Syndrome
- ☐ Delayed Radiation Injury
- ☐ Frostbite/Thermal Burns
- ☐ Other: _____

HISTORY

_____

_____

_____

PLEASE INCLUDE ALL OF THE FOLLOWING INFORMATION WITH YOUR REFERRAL (IF AVAILABLE):

- Relevant Diagnostic Imaging Reports such as: CXR, CT Chest, ABI, Vascular Studies
- Recent Bloodwork Including: HbA1C, CBC, ESR/CRP
- List of Medications and Allergies
- Past Medical/Surgical History
- Most recent Consults/Follow Up Notes
- Specialist Reports Including: Cardiology, Respiratory, ENT, Dermatology, Ortho/Vascular Surgery)

REFERRING PHYSICIAN INFORMATION

Name: _____ Tel: _____

OHIP #: _____ Fax: _____

CPSO #: _____ Date: _____

Signature: _____