

Fax Referrals to: 519-432-9529

Today's Date: _____	Referring Physician: _____
Patient's Name: _____ M / F / U	Ref. Physician Billing #: _____
Healthcard Number: _____ DOB: _____	Ref. Physician Signature: _____
Address: _____	Clinic Address: _____
City: _____ Postal Code: _____	Phone: _____
Home Phone: _____ Cell Phone: _____	Fax: _____
Email: _____	

Reason for referral (required):

DR. ROBERT BROWN MEMORIAL CARDIAC DIAGNOSTIC CENTRE	GENERAL SURGERY
<input type="checkbox"/> Echocardiogram <input type="checkbox"/> With Contrast <input type="checkbox"/> Murmurs <input type="checkbox"/> Valvular disorder <input type="checkbox"/> Chest pain and/or CAD <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Hypertension <input type="checkbox"/> Palpitations/Arrhythmias <input type="checkbox"/> Other: _____ <input type="checkbox"/> 24hr Ambulatory BP Monitor (\$80) <input type="checkbox"/> Holter Monitor <input type="checkbox"/> 48hr Holter Monitor <input type="checkbox"/> 72hr Holter Monitor <input type="checkbox"/> 7 day Holter Monitor <input type="checkbox"/> 12-Lead Electrocardiogram (ECG)	<input type="checkbox"/> Hernia or Gallbladder <input type="checkbox"/> Pilonidal Sinus <input type="checkbox"/> Breast Lump - Benign or Malignant <input type="checkbox"/> Thyroid nodule or thyroglossal duct cyst <input type="checkbox"/> Colon cancer <input type="checkbox"/> Fistula in ano, fissures, hemorrhoidectomy <input type="checkbox"/> Oral or parotid lesion
	PLASTIC SURGERY
	<input type="checkbox"/> Biopsy Clinic (size, location, diff dx. Req) <input type="checkbox"/> Biopsy Confirmed Skin Cancer <input type="checkbox"/> Cosmetic Skin Surgery - skin tag, cyst removal seborrheic keratosis (FEE)
	PEDIATRICS
	<input type="checkbox"/> Urgent Pediatric Consultation (no mental health) <input type="checkbox"/> Well Baby Checks
MSK CLINIC	INTERNAL MEDICINE, LIFESTYLE MEDICINE
<input type="checkbox"/> Knee, Hip or Shoulder pain <input type="checkbox"/> Back/Neck Pain (Injury Only - no chronic pain) <input type="checkbox"/> PRP, Nstride, Hyaluronic Acid injections (FEE) <input type="checkbox"/> Cortisone Injection <input type="checkbox"/> Physiotherapy, Orthotics, Custom Bracing	<input type="checkbox"/> Consultation
WELLNESS	GASTROENTEROLOGY
<input type="checkbox"/> Executive Health Medicals (FEE) <input type="checkbox"/> Registered Dietician <input type="checkbox"/> Registered Kinesiologist <input type="checkbox"/> Custom Orthotics/Footcare/Stockings <input type="checkbox"/> Botox/Filler and other cosmetics services	<input type="checkbox"/> Consultation
	PDT (PHOTODYNAMIC THERAPY) - FEE
	<input type="checkbox"/> Actinic damage or superficial skin cancer
	FITNESS PERFORMANCE TESTING
	<input type="checkbox"/> BodPod <input type="checkbox"/> Fit3D <input type="checkbox"/> RMR (Resting Metabolic Rate) <input type="checkbox"/> VO2 Max Testing