Bridgepoint Hospital
14 St. Matthews Rd.
Toronto, ON M4M 2B5
416-461-8252 x2371
bridgepointhealth.ca

BRIDGEPOINT
active healthcare

Outpatient MD Clinic Referral Form

Patient Information:

Name: _____ Date of birth: (dd/mm/yy)

Address: _____

Health card: _____ Version Code: _____

Daytime contact number: _____ Family doctor: _____

Emergency or Contact to arrange appointment (name, tel no., relationship):

_____

Service referred for:

- ☐ Endocrinology – Dr. D. Reiss
- ☐ General Internal Medicine – Dr. D. Reiss
- ☐ Geriatric Psychiatry – Dr. M. Lachmann
- Physiatry - Dr. C. Fortin
  - ☐ Consultation
  - ☐ Consultation + EMG

Reason for referral or question:

Please attach: recent lab data/neurological imaging, relevant specialist referrals, current list of medications and allergies.

Referring physician information:

Name: _____ Physician billing #: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

Physician signature: _____ Date: _____

Please fax referral form to 416-461-2089

We will contact the patient directly for an appointment.

Updated Dec 2015