MARKHAM STOUFFVILLE HOSPITAL
381 Church Street
P.O. Box 1800
Markham, Ontario
L3P 7P3

Childbirth & Children's Centre **Phone: (905) 472-7383**
Fax: (905) 472-7385

PHYSICIAN REFERRAL

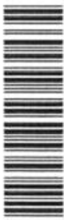
To:	
Specialty:	
Date:	**Fax:** ( )

Referring:			
Patient Name: ______		Date of Birth: *(day/mon/yr)*	
Address: ______		Health Card #	
Parents: *Last*	*First*	Home Phone:	Work Phone:
Mother's Name:			
Father's Name:			Work Phone:
Appointment Date: *(day,mon,yr)* ______			

Purpose of referral:

Other significant medical history:

Medication:



Referrring Physician Name:	**Referring Physician Signature:**	**Physician for follow-up:**
Physician number:		