Scope Medical

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Internal Medicine Referral

Please fax the completed form to 613-776-0403

Priority ☐ Routine ☐ Urgent

PATIENT INFORMATION

Last name | First name | Date of birth (YYYY-MM-DD)

Health card number | Version code | Sex | Phone

Address (street, city, postal code) | Alternate phone

Email (optional)

REFERRING PROVIDER

Name | OHIP billing number | CPSO / CNO number

Address | Phone

Fax (for the consultation report)

CONDITION FOR REFERRAL

- ☐ POTS (postural orthostatic tachycardia syndrome)
- ☐ Hypertension management
- ☐ Complex diabetes management
- ☐ Chronic disease management
- ☐ Other:

ATTACHED WITH THIS REFERRAL

- ☐ Past medical history
- ☐ Family history
- ☐ Allergies
- ☐ Current medication list
- ☐ Recent laboratory results
- ☐ Imaging / other reports
- ☐ Relevant clinic notes
- ☐ Other (describe below)

Other / additional information

Referral date (YYYY-MM-DD) | Referring provider signature