POLYCLINIC
FAMILY AND SPECIALTY MEDICINE

REFERRAL FORM

2 Champagne Drive (Champagne Centre), Toronto, ON M3J 0K2
Tel: 416-222-6160
www.polyclinic.ca hr@polyclinic.ca

PATIENT INFORMATION

Name: _____
Tel: _____
Address: _____
_____
DOB (M) _____ / (D) _____ / (Y) _____
HC# _____ VC _____
Referring Physician: _____
Provider #: _____

PLEASE CHECK ALL CONSULTATION AND/OR DIAGNOSTIC SERVICES REQUESTED

SPECIALTY DEPARTMENT UNIT B17 TEL: 416-222-6160 Ext. 268, 269, 277, 278 FAX: 416-645-1978

- ☐ Allergy
- ☐ ENT
- ☐ Audio Testing
- ☐ VNG
- ☐ Endocrinology
- ☐ Gynecology
- ☐ Hepatology
- ☐ Fibroscan
- ☐ Nerve Conduction Study ext. 278
- ☐ Nephrology
- ☐ Orthopedic Surgery
- ☐ Plastic Surgery
- ☐ Respirology
- ☐ Urology
- ☐ Vascular Surgery

NEUROLOGY DEPARTMENT UNIT B10 TEL: 416-222-6160 EXT. 255, FAX: 416-645-1979

- ☐ Neurology Consult

PDS CARDIAC IMAGING UNIT B10, TEL: 416-222-6160 EXT.243, FAX: 416-386-1023

Cardiology
- ☐ Cardiology Consult

Cardiac Diagnostic Testing
- ☐ ECG
- ☐ Echocardiogram
- ☐ Stress Test
- ☐ Stress Echocardiogram

Holter Monitor Testing
- ☐ 24 hrs ☐ 48 hrs ☐ 72 hrs
- ☐ 7 day ☐ 14 day ☐ ABPM

Indications
- ☐ Shortness of Breath
- ☐ History of MI / Stroke
- ☐ Angina / Ischemic Heart Disease
- ☐ Palpitations
- ☐ Heart Murmur
- ☐ Dizziness / Lightheadedness
- ☐ Syncope
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Family history of heart disease
- ☐ Atrial Fibrillation / Arrythmias
- ☐ Abnormal ECG
- ☐ Other: _____

NORTH YORK ENDOSCOPY CENTRE UNIT B19 TEL: 416-645-5145 FAX: 416-645-1401

- ☐ General Surgery Consult
- ☐ Gastroenterology Consult
- ☐ Gastroscopy
- ☐ Colonoscopy

NORTH YORK PULMONARY FUNCTION CENTER UNIT B21 TEL: 416-636-6664 FAX: 416-636-8999

- ☐ Respiratory Consult
- ☐ Complete PFT
- ☐ Spirometry
- ☐ Resting Oximetry
- ☐ Methacholine Challenge Testing
- ☐ Pre/Post Bronchodialator

NORTH YORK SLEEP AND DIAGNOSTIC CENTRE UNIT B15 TEL: 416-642-4232 FAX: 416-642-4234

- ☐ Consultation and Sleep Study
- ☐ Consultation Only
- ☐ Sleep Study Only

PDS DIAGNOSTIC IMAGING UNIT B23 TEL: 416-741-2766 FAX: 416-741-6015

- ☐ X-Ray _____
- ☐ BMD _____
- ☐ Mammography _____
- ☐ Ultrasound _____
- ☐ Vascular Ultrasound _____
- ☐ Biopsy _____
- ☐ Injection _____
- ☐ Other _____

Name of Physician / NP: _____ Location: _____

Reason for Referral (Required): _____

_____

_____

_____

_____

Signature of Referring Physician / NP: _____ **Date:** _____