INTEGRA
HEALTH CENTRE

Integra Health Centre
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Patient Referral Form

Patient Information

Last Name:	**First Name:**	**D.O.B:**
Email:	**Phone #:**	
Address:		
City:	**Province:**	**Postal Code:**

Referring Physician Information

Referring Physician:	**Billing #:**	
Phone #:	**Fax #:**	
Office Address:		
City:	**Province:**	**Postal Code:**

Referral Information

Service(s)

☐ Rheumatology
☐ Respirology
☐ Sleep Consult

Reason for Referral:

☐ **URGENT**

Attached: ☐ Bloodwork ☐ Clinical Notes ☐ Imaging

*** Please fax referral to **416-777-9365** and patient will be contacted with appointment time and date.*