

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: <i>(Print first, last)</i> _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

Request for Patient MRN

Complete this form when requesting new MRN for a patient at Southlake Health.

ALL FIELDS ARE MANDATORY FOR MRN CREATION.
Forms with missing information will not be processed and returned to sender.

*Patient email not mandatory

Fax completed forms to 905-853-2211

Patient Name as it appears on Health Card _____

Patient Date of Birth dd / mm / yy Patient Birth Sex _____ Reason for Visit _____

Patient Health Card Number _____

Patient Address _____

Patient's Email* _____

Reason for MRN creation _____

Physician Name requesting MRN _____

Physician Contact Phone _____ Email _____

Physician Address _____

Important: Please do not include any patient related orders on this form.
Expected turn around time for MRN creation is 1-2 business days.