

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>

ADC Surgical Ambulatory Booking Form

Fax to Patient Scheduling 905-853-2211

THIS FORM IS FOR APPOINTMENT REQUESTS ONLY AND IS NOT A PHYSICIAN-TO-PHYSICIAN REFERRAL

PATIENT INFORMATION

Patient Name: <i>(print first, last)</i> _____				Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>	
Patient Address: <i>Street Number + Name</i> _____		<i>Apartment</i> _____	<i>City</i> _____	<i>Province</i> _____	<i>Postal Code</i> _____
Health Card Number: _____		Version Code: _____		MRN: _____	
Primary Phone: _____				Other Phone: _____	

REFERRAL INFORMATION

Appointment Reason This is not an order

BCG
 Albumin
 Paracentesis
 Paracentesis+Albumin
 Thoracentesis
 Phlebotomy
 ACTH Treatment

Treatment Schedule

Schedule Repeat treatment: q _____ (e.g., q week) Number of cycles: x _____

Bronchoscopy

Date: dd / mm / yy Time: _____:_____

Referring Provider (if not the person entering the order): _____

PLEASE READ - IMPORTANT REMINDER

Appropriate Order Set MUST be filled out in Hold Queue for clinic use.

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referred by: *Check (✓) one* Family Physician Nurse Practitioner

Ordering Provider Name: <i>(print first, last)</i> _____	Billing #: _____
Date of Referral: <u>dd</u> / <u>mm</u> / <u>yy</u>	Signature: _____
Phone Number: _____	Fax Number: _____
Family Provider Name if not Ordering Provider: <i>(print first, last)</i> _____	Billing #: _____

INCOMPLETE FORMS WILL NOT BE PROCESSED

