HEADWATERS PLASTIC SURGERY

plastic and reconstructive surgery

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Date of referral (YYYY/M/DD): _____

A. REFERRING PROFESSIONAL (stamp or complete)

Physician Name:	Phone Number:	Fax Number:
Mailing Address:	Physician Billing Number:	Email Address:
	Signature:	

B. PATIENT INFORMATION (label or complete)

Address:	Health Card No. (Version Code)	Full Name:	DOB:
	Main Telephone:	WSIB claim # *(if applicable)*	Sex □ Male □ Female

C. REASON FOR REFERRAL

Urgency: □ Emergent <1 week □ Urgent <4 weeks □ Semi-urgent 4-8 weeks □ Elective

Presenting complaint/nature of injury: □ Hand & Upper Limb □ Breast □ Skin Cancer □ Benign Lesion

Date of injury: □ Other:

Attach reports and include any details/supporting clinical documentation/investigation:
(Please send EMG report for carpal tunnel consultation)

If you have received this fax in error, please contact the referring physician. Thank you.

(last updated: 11-21-2018)