Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

The Early Arthritis Clinic

Patient Referral Form

Telephone: 905-883-2004 **Fax: 905-883-0772**

(Print Last, First)
Patient Name:

Street: *Apt:* *City/Town* *Province* *Postal Code*
Address: #

Health Card Number: Version Code: *(dd/mm/yyyy)* Date of Birth:

Primary Number: ( ) ☐ Cell ☐ Home ☐ Work ( )

Secondary Number: ( ) ☐ Cell ☐ Home ☐ Work ( )

Emergency Contact Name: Relation: Telephone Number: ( )

Physician Information

Referring Physician Name: *(Please Print)*_____ Referring Physician Signature _____

Referring Billing Number: _____

Address: _____ City: _____ Postal Code: _____

Telephone Number: _____ Fax: _____

Family Physician same as above ☐ Yes ☐ No If no, please provide information below

Family Physician Name: _____

Address: _____ City: _____ Postal Code: _____

Telephone: ( ) _____ Fax Number: ( ) _____

Reason for Referral

Three or more swollen joints ☐ Yes ☐ No
OR
Morning Stiffness of 30 minutes or more ☐ Yes ☐ No
OR
Metacarpal Joint/Metatarsal Phalangeal Joint Involvement ☐ Yes ☐ No

Additional Section

Please advise patient to bring a copy of recent Lab Tests and Radiographic Reports.
The patient will be contacted directly with a Clinic appointment date and time.

Lab Tests Attached : _____ Completed Date: _____ *(dd/mm/yyyy)*

Radiographic Reports Attached: _____ Completed Date: _____ *(dd/mm/yyyy)*

7735 (Feb 2018)