**Haliburton Highlands Internal Medicine Clinic**
P.O. Box 30 Minden, On K0M 2K0
(705) 286-2140 ext 3901
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# Haliburton Highlands Health Services Internal Medicine Clinic Referral Form

## Patient Information

Name: _____

Address: _____

City: _____ Postal Code: _____

Date of referral: _____

PCP: _____

PCP contact: _____

Gender: _____

DOB (dd/mm/yy): _____

Phone number: _____

Alternate Phone: _____

Health Card Number: _____

Version Code: _____

## Reason for Referral

**Urgency:** ☐ Routine ☐ Urgent

**Goal of Referral**:

☐ Advice/Question ☐ Co-Management ☐ Diagnostic Clarification ☐ 2nd Opinion
☐ Re-Referral ☐ 3rd Party Request ☐ Other

Name of suspected diagnosis/problem triggering referral

Brief description of history, management, and investigations

*Please attach an updated cumulative patient profile (CPP) and all **relevant** laboratory and diagnostic investigations from last **6 months**

## Referring Provider Information

Name: _____

Title: _____

Date: _____

Contact Number: _____

Billing Number: _____

Signature: _____