UHN Toronto General Toronto Western Princess Margaret Toronto Rehab

Referral Form
Immunodeficiency Clinic

Toronto General Hospital
585 University Ave.
13th Floor NU – Rm 1300
Toronto, ON M5G 2N2

In order to have your patient seen in the clinic we require the following information. **Please note: if the patient does not have OHIP, there will be a fee to see the doctor**. If you need further details, please call us at: 416-340-5077

Referring doctor's name: _____ Billing number: _____
Phone: _____ Fax: _____
Do you request a specific doctor? Please specify _____ or first available: ☐

Reason for referral: _____
_____

Patient information
Patient's full name: _____
Address: _____
City: _____ Province: _____
Phone number: _____ ☐ Okay to leave a message
OHIP Number: _____
If the patient does not have OHIP please indicate what type of coverage they do have and include a copy of it with this completed referral form:
_____

Is the patient aware of their positive HIV status? ☐ Yes ☐ No

Please send a copy of the following information:

- ☐ HIV serology (note: we will not see the patient until this is acquired)
- ☐ CBC, Chemistry, CD4
- ☐ Viral Load
- ☐ Syphilis and or history of other STDs
- ☐ Hepatitis A, B, and C status
- ☐ Current medication record
- ☐ Vaccination History: Hep B_____ Hep A_____ Pneumovax_____
- ☐ Medical History
- ☐ Other:_____
  _____

Comments:
_____
_____
_____
_____

Signature: _____ Date: _____

Please fax the completed form to the Immunodeficiency Clinic at: 416-340-4890
If you have any questions please call us at: 416-340-5077