Hamilton Health Sciences

ENT Clinic Referral Request

McMaster Site **FAX: 905-521-85520**
Pediatric **PHONE: 905-521-2100 Ext. 73879**

General Site **FAX: 905-527-6860**
Adult **PHONE: 905-521-2100 Ext. 43237**

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

Patient email address

Referral Date (yyyy/mm/dd) _____

Referring Healthcare Provider (print) _____

Referring Healthcare Provider's Signature _____ Fax _____

Phone _____ (ext) _____ **OHIP Billing Number** _____

☐ **Urgent** ☐ **Non-Urgent**

Referral Requested: ☐ **Pediatric** ☐ **Adult**

Physician Requested

☐ **EAR** _____ ☐ Korman ☐ MacLean

☐ **NOSE** _____ ☐ Reid ☐ Sommer

☐ **THROAT/MOUTH/NECK** _____ ☐ Khalife ☐ Any

Internal Referral from: ☐ ER ☐ Resident/Fellow ☐ Inpatient

Interpreter required: ☐ No ☐ Yes – Language Spoken _____

Audiogram attached? ☐ No ☐ Yes

Reason for Referral: _____

_____

Clinical History: _____

_____

_____

_____

_____

_____

_____

Date Received: (yyyy/mm/dd) _____ **Date Triaged:** (yyyy/mm/dd) _____

Triaged By: Printed Name _____ Signature and Designation _____