University Centre
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Toronto, ON, M5G 2A2
Tel: 416-597-3422 ext: 4200
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SENIOR RESIDENT CLINIC REFERRAL

Patient Information	
Name:	☐ M ☐ F
Address:	
Tel (primary):	
Tel (secondary):	
Alternate Contact:	
Date of Birth (mm/dd/yyyy):	
Health Card #:	VC:
WSIB#	☐ N/A
Interpreter? ☐ N ☐ Y: Language:	

Referring Physician	
Name:	
Address:	
Tel:	Fax:
Date:	Billing#
Signature:	

Referral Urgency: ☐ Routine ☐ Urgent - explain:

Refer to (name): SENIOR RESIDENT CLINIC	**Suspected Diagnosis:**
☐ Residents to triage referral	**Estimated Date of Onset:**

Requested Consultation:

- ☐ Acute/Subacute Musculoskeletal Injuries Location: _____
- ☐ Acquired Brain Injury
- ☐ Stroke
- ☐ Other:_____

Additional information/Referral question:

Treatment Goals:

- ☐ Pain management with medications
- ☐ Advice to direct therapy
- ☐ Diagnostic clarification
- ☐ Injection: Describe:_____
- ☐ Other:_____
- ☐

Past Medical History: (may be included on a separate sheet – i.e. EMR print out)

To be accepted, this application must include:

- ☐ Medication List (with allergies listed)
- ☐ Relevant Imaging Studies (X-Ray, Ultrasound, MRI, CT, etc…)
- ☐ Relevant Consultation Notes or Reports (i.e. Specialists, Physiotherapy, Occupational Therapy, etc…)