West Park HEALTHCARE CENTRE
Get your life back.

Addressograph if available

Tuberculosis Service Outpatient Referral Form

Please complete and return to the TB Clinic:

Fax: 416 243-3696

Tel: 416 243-3600 x32180

Date:

Name:	**Date of birth:**
Address:	**Phone 1:** **Phone 2:**
Family physician: **Referring physician :**	**Languages spoken and understood:**
Health card number: **Interim Federal Health:** **Private Insurance:**	

Reason for referral:

- All client's must be informed of the referral to West Park Healthcare Centre
- Referral must include demographics, typed medical history, reports, recent imaging