RED BLOOD CELL DISORDERS PROGRAM
TORONTO GENERAL HOSPITAL
Norman Urquhart Wing, 7th Floor, Room 700
585 UNIVERSITY AVE, TORONTO ON, M5G 2N2
TEL: 416-340-4882 FAX: 416-340-4559

Date Sent: _____

PATIENT INFORMATION			
Last Name:		First Name:	Date of Birth (dd/mm/yyyy):
Health Card #:	Version:	Patient Location details (home/inpatient):	Previous UHN patient: Y / N MRN, if known:
Street Address:			
City:		Province:	Postal Code003A
Phone (Home):		Phone (Cell):	Phone (Work):
Alternate Contact Name:		Relationship:	Phone (Home/Cell):
Referring Physician Name:	Referring Physician Billing Number:	Referring Physician Phone:	Referring Physician Fax:
Referring Physician Email:	Family Physician Name:	Family Physician Phone:	Family Physician Fax:

***CLINICAL INFORMATION REQUIRED* (Please include as much information as possible and FAX COPIES OF ALL CONSULTATION NOTES & REPORTS LISTED IN THE CHECKLIST)**

Reason for Consultation:

☐ Newly Diagnosed ☐ Second opinion
☐ Annual Expert Review & Recommendations
☐ Transfer of patient ☐ Other
☐ Shared Care _____
☐ **URGENT** – you will be contacted by clinic staff to discuss

Diagnosis:

Sickle Cell Disease
□ HbSS
□ HbSC
□ HbS/β Thalassemia

Thalassemia
□ β Thalassemia Major
□ β Thalassemia Intermedia
□ HbH Disease

Other:
_____

Patient informed of diagnosis?
☐ Yes ☐ No

Interpreter Services?

☐ No
☐ Yes, Please specify patient's primary language:

Blood Transfusion Support:

If this patient requires blood transfusions, are you able to assume responsibility for/supervise these?

□ Yes
□ No

CHECKLIST FOR A COMPLETE REFERRAL

☐ Referral Form & Additional Consult Notes ☐ Recent Bloodwork - **CBC & Hb Electrophoresis** ☐ Diagnostic Imaging Reports

NOTE: ANY REFERRALS THAT ARE INCOMPLETE AND DO NOT PROVIDE CBC & HB ELECTROPHORESIS CANNOT BE TRIAGED. ALSO, A "NO SHOW" WILL NOT BE REBOOKED AUTOMATICALLY AND WILL REQUIRE A NEW REFERRAL.

OFFICE USE ONLY:			
Date Received:	Appointment Date & Time:	Interpreter Booked? Y/N	Priority
Physician Signature:	Date:	Comments:	