

Collingwood General & Marine Hospital
459 Hume Street
Collingwood, ON L9Y 1W9
Phone 705-444-8606, Fax 705-445-8103
Emergency Department
Outpatient Referral Form

Patient Label

Date: _____

To: Dr. _____

From: Dr. _____ **Billing #:** _____

Urgent : _____ (referring physician has discussed case with consultant)

Non-urgent: _____ (referral to be faxed to consultant and priority will be assessed when office is next open)

Details:

Signature of Referring Physician: _____

Attached:

ER Record: _____ **ECGs:** _____ **Lab:** _____ **Imaging:** _____

Faxed (date/time): _____ **Initials:** _____