SIMCOE PLACE HEALTH CLINIC
200 Front St. West, Unit C021D, Toronto, ON M5V 3K2
T: (416) 599-9000 F: (416) 599-9001

Internal Medicine Referral Form

Dr. Christopher David Gallivan M.D.

Patient Information		
Last Name :	First Name :	D.O.B :
OHIP # :	Cell : Text: ☐Yes ☐No	Home Phone :
Address :		
City	Province	Postal Code:

Referring Physician Information		
Referring Physician:		Billing #:
Phone :	Fax :	
Office Address:		

Referral Information

☐New Referral ☐ Second Opinion ☐Re- Referral

Reason for Consult

☐ Diabetes	☐ Dyslipidemia	☐ Metabolic syndrome	☐ Thromboembolic Disease
☐ Thyroid	☐ Chronic Fatigue	☐ Benign Hematology	☐ Unexplained weight loss
☐ Obesity	☐ Anemia NYD	☐ Geriatric 65 years+	☐ Endocrine Disorders
☐Hypertension	☐ Chest Pain NYD	☐ Thyroid Disorders	☐ Auto-immune Disorders
☐ Syncope	☐ Infectious Disease NYD	☐ Chronic Kidney Disease	☐ Rheumatological Disorders

☐ Other :

Additional Information:

Specialist seen previously? ☐ Yes ☐ No *if yes when?*	Prior hospital admission? *(past 2 years)* ☐ Yes ☐ No *if yes when & where?*
Diagnosis *(if available)* : Date of diagnosis *(if known)* :	Past Medical History:
Current Medication: ☐ Attached	Allergies: ☐ Attached

Requirements for Triage (include all relevant documentation)

• Blood work ☐ Attached	• All consultant letters ☐ Attached	• Microbiology ☐ Attached
• Diagnostic Imaging ☐ Attached	• All discharge summaries ☐ Attached	• Pathology ☐ Attached

Signature:__________________________Date: __________________________

Please Email Form to: info@simcoehealth.ca when completed to book appointment.