Royal Victoria Regional Health Centre

PATIENT NAME: _____

DOB: _____

HRN: _____

HC#: _____

PHONE: _____

Chiropody Clinic Referral
Medicine Treatment Clinic

Phone: 705-728-9090 Ext: 23300
Fax: 705-728-3039

Please indicate urgency: ☐ 4 Weeks ☐ 2 Weeks ☐ First Available

Diabetic ☐ **Yes** ☐ **No**

Diagnosis/Goal(s) of Treatment:

Current Medications:

Relevant Lab/Diagnostic Tests Pending or Results: *Please attach with referral or fax to 705-728-3039*

Signature of Referring Physician _____ Date _____

Referring Physician Name Print _____ Physician Billing Number _____

Physician Office Phone _____ Physician Office Fax _____

For Office Use
Triage By: _____ Triage Date: _____
Action Plan:
_____

201 Georgian Drive | Barrie ON | L4M 6M2 | 705.728.9802
www.rvh.on.ca

R.CDMCR

Inspiring care...