Medical Record #: ____________________ _______________

Patient Name: ______________________________________

Address:____

DOB: _________________ Age: ________ ☐ Female ☐ Male

OHIP #: ___________________ _____________________Version Code ___________

Infectious Diseases Clinic Referral Form
Ambulatory Clinic

Please Email Referrals to:
Melissa.terpou@sjhc.london.on.ca
OR
Mahshid.mohammadi@sjhc.london.on.ca

TO REQUEST AN APPOINTMENT: Please fax the completed referral and all requested clinical information.
Please notify your patient of appointment date, arrival time and instructions.

PATIENT LOCATION

☐ Home ☐ Hospital ☐ Longterm Care Facility
Preferred contact: ___________________________
☐ Interpreter required Language: ___________
☐ Physical/Other limitations _________________
ALLERGIES: ________________________________

IPAC SCREENING

Patient has tested positive for:
☐ **VRE** ☐ **MRSA**
☐ **ESBL** ☐ ***Clostridium difficile***
☐ **NO resistant organism**

REFERRAL INFORMATION

Appointment Type: ☐ **New** ☐ **Follow-Up**

Reason for Referral:

Antibiotics (Current, recent for current illness, dates):

Urgency of Referral: ☐ ≤ 72 hours ☐ > 72 hours and < 2 weeks ☐ > 2 weeks

Please include the following:
☐ History of current issue
☐ Relevant consult and/or operative notes
☐ Full medication list
☐ Past medical history

Relevant Investigations (include copies):
☐ Microbiology (ie Bacteriology, Virology, Serology)
☐ Laboratory
☐ Radiology
☐ Other

REFERRING PHYSICIAN INFORMATION

Referring Physician Name: (Please print)

Referring Physician Billing Number:

Referring Physician Signature:

Referring Physician fax: **Date:**

OFFICE USE ONLY
Appointment Date (d/m/y): ____________________ Time: _______________ Clinic: ___________________________
Notification (d/m/y): _______________ ☐ Referring Office ☐ Patient ☐ Other:____________ Initials:_________________
Isolation: ___________________________