Transitional Beds Program Physician to Physician Referral Form

PATIENT LABEL

DATE: ______________________________

REFERRING MD / BILLING #:
____

REFERRING SERVICE:
____

REASON FOR REFERRAL: ______________________________

PRIMARY DIAGNOSIS: ______________________________

SECONDARY DIAGNOSES: ______________________________
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____

SURGICAL PROCEDURES COMPLETED IN HOSPITAL:
____
____
____

PENDING INVESTIGATIONS: ______________________________
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ANY INVESTIGATIONS THAT WILL NEED TO BE DONE IN THE NEXT 6 WEEKS?

- **LABS:**
- **IMAGING:**
- **OTHER:**

UPDATED MEDICATION LIST MUST BE ATTACHED TO REFERRAL
Include start/end dates for any time-limited meds (antibiotics, anticoagulants)

FAX TO: (905)741-0527
Questions? Call 905-572-6824