Religious Hospitallers
of Saint Joseph
of the Hotel Dieu of Kingston
HOTEL DIEU HOSPITAL

PATIENT INFORMATION

Name ______________________________

Date of Birth (YYYY/MM/DD) ______________________

Health Card # ______________ Version ________

Phone # Home: ______________________________

Work: ______________________________

Alternate: ______________________________

Address ______________________________

____

Anesthesiology Chronic Pain Clinic Referral Form

Telephone: **613-549-6666 Ext. 3472**
Facsimile: **613-548-1375**
www.hoteldieu.com

Referring Physician Information

Physician Printed Name: ______________________ Physician Signature: ______________________

Specialty: ______________________ Center: ______________________

Telephone: ______________________ Fax: ______________________

Family Physician: ____

Date of Referral: ______________________ Appointment Date: ______________________
YYYY/MM/DD YYYY/MM/DD

Disability Insurance: ☐ None ☐ ODSP ☐ WSIB ☐ Private Disability ______________________

Reason for Referral: ____

____

____

____

Current Medications: ____

____

____

____

Recent Investigations and Dates: ____

____

____

____

FAX referral for <u>new</u> patients to Anesthesiology Chronic Pain Clinic
Fax # 613-548-1375
Please inform patients that:

1. They will be contacted with an appointment date and time.
2. Remind your patient to bring their health card.