



Patient Information

Name: _____

Address: _____

DOB: _____ OHIP: _____

Cell #: _____ Home #: _____

Email: _____

Referral to:

- General Pediatrician:** Dr. S. Sit Dr. A. Lavorato Dr. M. Prashar Dr. A. Donado
- Allergist** (Dr. A. Ciccolini)
- Pediatric Respirologist** (Dr. R. Verma)
- Afterhours Clinic Pediatrician** (Urgent same day or next day)

Reason for Referral:

Referring MD: _____ **Billing #:** _____

Address: _____

Phone: _____ **Fax:** _____

Signature: _____ **Date:** _____

PLEASE FAX REFERRAL TO: 905-264-0801 OR EMAIL TO: admin@rutherfordmedicalclinic.ca