



Medical Day Unit
Referral Form
Phone: (613) 267-1500 ext. 4234
Fax: (613) 267-2041

Name: _____
Address: _____
City: _____ Postal Code: _____
Telephone: _____
Alternate or work#: _____
Family Physician: _____
HIN: _____ DOB: _____
MRN _____

****Please ensure that all applicable forms are sent at the time of referral.****

Referring Physician _____ / _____
(signature) (print please)

Date: _____

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Physician Orders

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Required Documentation:

▲ Blood product orders require a current “Consent for Blood Products”, signed by ordering Physician and patient attached. Consents are current for one year and held in MDU for same.

▲ IVIG orders require that the applicable Ministry of Health and Long Term Care IVIG Request Form be complete and attached. “MOHLTC IVIG Form” or for neurology patients “MOHLTC IGSP Form”

▲ Blood work required: ☐ YES ☐ NO *If yes, attach “PSFDH lab requisition”.

This ambulatory clinic supports stable out-patients with non-urgent treatment needs. Patients need to be able to transfer independently, toilet themselves and should be able to tolerate sitting for the duration of their treatment. We will do our best to accommodate short notice treatments but may not always be able to do so related to patient volumes.