APHERESIS UNIT - REFERRAL FORM

MD Name: _____ **Date:** _____

Hospital: ☐TGH ☐TWH ☐PMH ☐Mount Sinai ☐External (hospital name) _____

Referring Dept: ☐MOT ☐Nephrology ☐Hematology ☐Neurology ☐Other _____

MD Phone: _____ **Fax:** _____

Patient Name:_____ **MRN:** _____

Type of Treatment:

- ❑ Therapeutic Plasma Exchange
- ❑ Red Blood Cell exchange

Reason for Referral: _____

_____

_____

Medical History: _____

_____

_____

PLEASE CHECK IF COMPLETED:

- ❑ Patient informed of purpose of clinic
- ❑ Accompanying updated detailed **legible** medical history

INFORMATION REQUIRED

1. Contact Information:

- ❑ Patient telephone numbers (home, work, mobile, alternate contact)
- ❑ Home address
- ❑ Family/General Practitioner's name/address/telephone/fax
- ❑ Referring Specialist's name/address/telephone/fax/billing number

2. Patient Information:

- ❑ Name of patient
- ❑ OHIP number
- ❑ Date of birth
- ❑ Languages spoken
- ❑ Current Height (cm) & Weight (kg)
- ❑ Current list of Medications and Allergies

3. Laboratory results:

- ❑ Electrolytes
- ❑ CBC
- ❑ Creatinine

4. **Other relevant investigations**, if done within 1 year of first appointment:

Referring MD's signature: _____

CONTACT
APHERESIS UNIT
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Fax: (416) 340-3348

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab
COURAGE LIVES HERE

Last Updated July 2020