Joint Injection Clinic
Norfolk General Hospital
365 West Street Simcoe,
Ontario N3Y 1T7

Procedure:_____
Date:

Frequency:

Signature: _____

Joint Injection Clinic Referral Form

FAX TO # 519-429-6895

(*For joint injection of knee/hips and joint injury assessment)

PATIENT INFORMATION (please print)

Surname: _____ Given Name: _____

Date of Birth: _____ Health card number: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Alternate: _____ Date of referral (YYYY/MM/DD)

REFERRING CLINICIAN INFORMATION

Name: _____ Physician Number: _____

Address: _____ City: _____Postal Code: _____

Phone: _____ *Fax: _____ Email: _____

***Note – fax and phone numbers MUST be provided so the physician's report can be faxed to you.**

COPY OF CONSULT LETTER MUST BE INCLUDED WITH REFERRAL

Please have patient bring any s-ray / DI films to their appointment

REASON FOR REFERRAL