WRHN
Waterloo Regional
Health Network

Emergency Department
REFERRAL FOR CONSULTATION

REFERRAL TO	
Service: ☐ On Call	Date:
Physician:	Fax:
REFERRAL FOR	
Patient Name:	Tel:
Regarding:	

DETAILS

FOLLOW-UP

☐ Routine / Elective
☐ Urgent *(urgent referrals must be discussed with clinician on call)*
☐ As discussed: ☐ <72h ☐ 1 Week ☐ > 1 week ☐ Other: _____

Signature: _____ ☐ Midtown (GRH) ☐ Queen's Blvd. (SMGH)

Referring Clinician Name: _____ Billing #: _____

IMPORTANT: PLEASE CONTACT THE PATIENT DIRECTLY (AND NOT THE ED) WITH THEIR APPOINTMENT TIME

If there are any questions regarding this referral, please contact the Emergency Department.

Version 10 (Apr 2 2025) R. S. Sahsi