Referral to

Second Medical Inc.
563 Eglinton Ave. West
Toronto, ON M5N 1B5
Phone: 416-551-7700
Fax: 647-689-2012

SECOND MEDICAL
YOU DESERVE A SECOND OPINION

Patient's Information

Name _____

Address _____

Contact Number _____

Health Card Number _____

Date of Birth _____

Reason for Referral _____
_____
_____

Clinical History _____
_____
_____

Medications _____
_____

NOTE: Please attach results of relevant investigations

Referring MD

Name _____

Address _____

Telephone Number _____

Fax Number _____

OHIP Billing Number _____

Signature _____

Once complete, please fax to 647-689-2012