MEDICAL DAY CLINIC REFERRAL

Fax: 613-961- 7517
Phone: 613-969-7400 x 2428

☐ Belleville General Hospital
265 Dundas Street East Belleville, ON K8N 5A9

☐ Trenton Memorial Hospital
242 King Street, Trenton ON K8V 5S6

Date: DD/MM/YYYY _____ Triage Level: ☐ Urgent (1-4 days) ☐ Standard (>1 wk)
Patient Demographics: ☐ Male ☐ Female Age: Code Status:

Last name:	First Name:
Health Card #:	Date of Birth: (DD/MM/YYYY)
Telephone number:	Address:
City:	Postal Code:
Primary Diagnosis:	
Secondary Diagnosis:	Allergies:

Procedure/Treatment	QHC Order Set Required	DO NOT WRITE IN THIS SPACE
PRBC Blood Transfusion	x	**QHC Order Set required**
Platelets		Attach separate order
FFP		Attach separate order
IVIG	x	**QHC Order Set required**
Iron Sucrose	x	**QHC Order Set required**
Therapeutic phlebotomy	x	**QHC Order Set required**
Paracentesis		Attach separate order
Pamidronate		Attach separate order
Magnesium		Attach separate order
Calcium		Attach separate order
IV antibiotics		Attach separate order
Bone Marrow Aspiration **(BGH ONLY)**		Attach separate order
Other: (Attach separate order)		

**** Please ensure all supporting documentation is provided at the time of referral: current lab results, MOHLTC forms, current medication list *****

Referring Physician (please print) _____Phone: _____

Referring Physician Fax: _____

Referring Physician acknowledges they have obtained patient consent for this procedure/treatment: ☐