Haliburton Highlands
Internal Medicine & Respirology Clinic
Minden Health Hub
P.O. Box 30 Minden, ON K0M 2K0
(705) 286-2140 ext 3901

HHHS Internal Medicine & Respirology Clinic Referral Form

Patient Information

Name: _____

Address: _____

City: _____ Postal Code: _____

Date of referral: _____

PCP: _____

PCP contact: _____

Gender: _____

DOB (dd/mm/yy): _____

Phone number: _____

Alternate Phone: _____

Health Card Number: _____

Version Code: _____

Reason for Referral

Urgency: ☐ Routine ☐ Urgent

Goal of Referral:

☐ Advice/Question ☐ Co-Management ☐ Diagnostic Clarification ☐ 2nd Opinion
☐ Re-Referral ☐ 3rd Party Request ☐ Other

Name of suspected diagnosis/problem triggering referral

Brief description of history, management, and investigations

*Please attach an updated cumulative patient profile (CPP) and all **relevant** laboratory and diagnostic investigations from last **6 months**

Referring Provider Information

Name: _____

Title: _____

Date: _____

Contact Number: _____

Billing Number: _____

Signature: _____