CAMP NORTHLAND B'NAI BRITH
4250 Haliburton Lake Road
Haliburton, Ontario K0M 1S0

Physician Referral Form

Referring Physician: ______________________________

Referring Physician OHIP #: ______________________________

Date of Referral: ______________________________

Patient Name: ______________________________

Patient OHIP #, DOB: **OHIP:** ____________________ **DOB:** ______________

Reason for Referral:

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Consultant Note **(please send form back to camp with patient):**

Diagnosis: ______________________________

Treatment/Plan: ______________________________

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Follow Up: ☐ **None Needed**

☐ ______________________________